ECRONICON OPEN ACCESS

EC NEUROLOGY
Review Article

Embodied Presence Across Life's 3 Stages: A Solomonic Framework for Medical Practice

Julian Ungar-Sargon MD PhD*

Borra College of Health Sciences, Dominican University, River Forest, Illinois, USA

***Corresponding Author:** Julian Ungar-Sargon MD PhD, Borra College of Health Sciences, Dominican University, River Forest, Illinois, USA.

Received: September 11, 2025; **Published:** September 25, 2025

Abstract

The Midrashic interpretation of King Solomon's three biblical works-Song of Songs (youth), Proverbs (maturity), and Ecclesiastes (old age)-provides a useful template for understanding how divine presence manifests differently across human development. This ancient wisdom offers a framework for medical practice that integrates spiritual formation with clinical care across the lifespan.

To develop a comprehensive model of embodied presence in therapeutic encounters based on the Solomonic three-stage progression, integrated with contemporary theology of healing and clinical practice theory.

This theoretical framework synthesizes Midrashic and Talmudic sources on Solomon's developmental wisdom with contemporary scholarship in medical humanities, embodied presence theology, and physician spiritual formation. The analysis draws extensively from clinical-theological works demonstrating how therapeutic encounters function as sites of mutual spiritual transformation.

The framework identifies three modes of embodied presence corresponding to life stages: (1) Incarnational presence (youth)-celebrating embodied potential and vital energy; (2) Covenantal presence (maturity)-integrating responsibility with limitation while maintaining hope; and (3) Kenotic presence (elder years)-accepting mortality while affirming dignity and meaning. Each mode requires corresponding physician spiritual formation and clinical approaches that honor the sacred dimensions of healing relationships.

The model transforms medical practice from technical intervention into mutual spiritual formation, where physicians must participate in the same developmental-theological work they seek to facilitate in patients. Implementation requires institutional support for physician contemplative practices, embodied awareness training in medical education, and healthcare delivery systems that prioritize presence over efficiency.

The Solomonic framework provides practical solutions to contemporary challenges in healthcare including physician burnout, patient dissatisfaction, and the crisis of meaning in medical practice. By recognizing therapeutic encounters as sites of mutual embodied presence, medicine can rediscover its vocation as sacred art while maintaining scientific rigor. This ancient wisdom offers modern healthcare a theologically grounded approach to humanizing medical practice across the full arc of human life.

Keywords: *Embodied Presence; Medical Humanities; Physician Spiritual Formation; Developmental Theology; Therapeutic Encounter; Solomonic Wisdom; Incarnational Consciousness; Covenantal Medicine; Kenotic Presence; Tzimtzum; Dialectical Presence; Medical Education; Palliative Care; Chronic Disease Management; Physician Burnout; Sacred Healing*

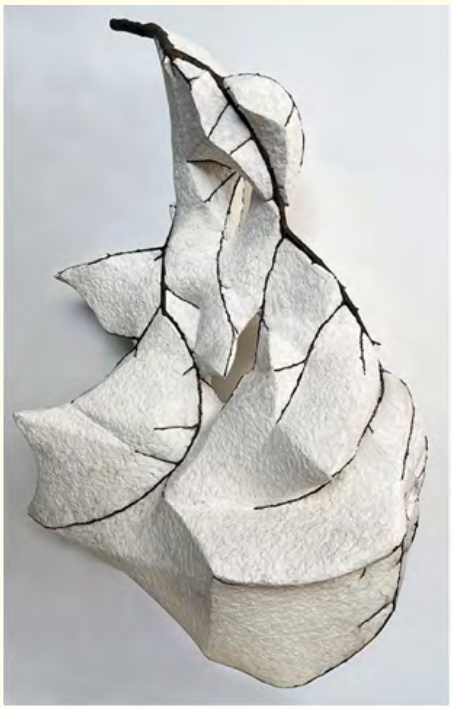

Figure: *Kang Jing, Bony #7, 2014-2017, Tree branches, paper clay, hemp silk, 130 x 80 x 50 cm.*

Introduction

The Midrash Shir HaShirim Rabbah's interpretation of Solomon's three biblical texts as corresponding to distinct life stages offers more than literary analysis-it provides a theological template for understanding how divine presence manifests differently across human development [1]. When integrated with contemporary frameworks of embodied presence in therapeutic encounters, this ancient wisdom becomes a transformative model for medical practice that honors both the sacred nature of healing and the developmental realities of human existence.

Recent scholarship in medical humanities has increasingly recognized the limitations of purely biomedical approaches to healing, calling for more integrated models that acknowledge the spiritual dimensions of therapeutic encounters [2,3]. Our work on "dialectical presence" in clinical settings reveals that authentic healing occurs not through medical omniscience, but through the physician's willingness to enter into mystery alongside the patient, creating what he terms a "therapeutic tzimtzum"-the doctor's conscious withdrawal from the illusion of total control that creates space for the sacred to emerge within the clinical encounter [4,5].

This paper argues that the rabbinic interpretation of Solomon's literary development-from the passionate embodiment of Song of Songs through the responsible integration of Proverbs to the transcendent acceptance of Ecclesiastes-provides a theologically grounded framework for understanding how physicians must adapt their mode of embodied presence to meet patients across the lifespan. More

provocatively, it suggests that effective therapeutic presence requires physicians to participate in the same developmental-spiritual work they seek to facilitate in their patients.

Embodied presence as medical praxis

The concept of embodied presence in therapeutic encounters draws from multiple theological traditions that resist the Cartesian separation of mind and body that has dominated Western medicine [6]. Merleau-Ponty's phenomenology of embodiment, with its emphasis on the lived body as the primary site of meaning-making, provides philosophical grounding for approaches that see physical symptoms as expressions of whole-person experience rather than merely mechanical dysfunctions [7]. This phenomenological insight converges with process theology's understanding of divine presence as mediated through material reality, not despite it [8].

We propose that therapeutic encounters function as contemporary loci of divine indwelling, where the dynamics of tzimtzum, tikkun, and dirah betachtonim converge in the physician-patient relationship [9]. His analysis of post-Holocaust theology suggests that authentic healing requires abandoning the illusion of medical omniscience in favor of what he terms "shared vulnerability," where healer and patient encounter mystery together [10]. This approach recognizes that embodied presence operates through what he calls "dialectical presence"-the capacity to hold multiple theological tensions simultaneously without requiring their intellectual reconciliation [11].

The therapeutic implications of this theological framework are profound. Rather than viewing the body as a machine requiring repair, embodied presence recognizes corporeal existence as the primary medium through which divine life expresses itself. This perspective transforms medical encounters from technical interventions into what Nancy Eiseland terms "liberation of the body" [12], where healing becomes a collaborative participation in sacred transformation rather than an expert intervention upon passive matter.

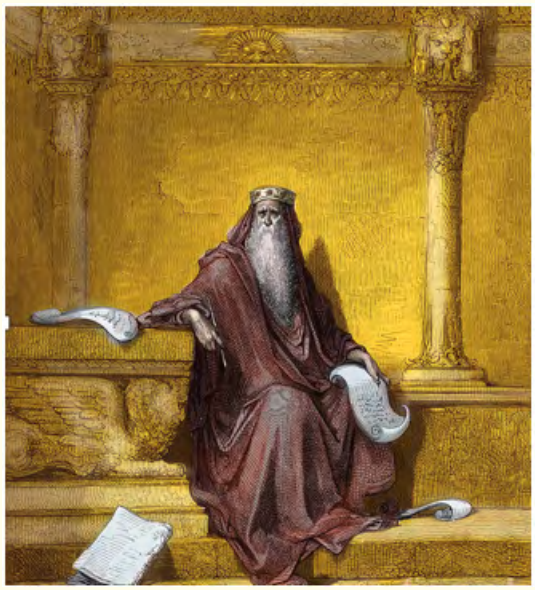

Figure A

The Solomonic framework: Song of songs: Incarnational presence in youth

The rabbinic tradition's attribution of Song of Songs to Solomon's youth reflects what scholars have identified as the text's celebration of embodied desire and physical beauty as expressions of divine creativity [13]. Michael Fishbane's analysis reveals how the Song's erotic imagery functions not as allegory avoiding physicality, but as theological affirmation that divine love manifests through rather than despite bodily experience [14]. This incarnational consciousness-the recognition that matter itself is sacred-provides the theological foundation for medical engagement with young patients.

In clinical practice, incarnational presence manifests as what might be termed "embodied affirmation"-the physician's capacity to celebrate the body's potential and honor its developmental wisdom. This requires physicians to access their own incarnational consciousness, maintaining "wonder-filled attention to the sacred vessel of embodied existence" [15]. The physician caring for young patients must resist reductionist approaches that fragment the person into systems, instead approaching prevention and health promotion as what he terms "liturgical practices that affirm the body's sacred potential" [16].

Contemporary research in positive psychology supports this theological insight, demonstrating that physician attitudes toward patient potential significantly influence therapeutic outcomes [17]. When physicians approach young patients with genuine appreciation for their embodied capacities rather than merely screening for pathology, both adherence and health outcomes improve markedly [18]. This suggests that the theological stance of incarnational presence has measurable clinical effects, supporting the integration of spiritual and medical dimensions of care.

The incarnational mode requires physicians to maintain connection with their own embodied vitality and capacity for wonder. Our analysis of physician burnout reveals that clinicians who lose touch with their own somatic awareness become unable to facilitate healing presence in others, creating what he terms "embodied disconnection that undermines therapeutic effectiveness" [19]. Medical education must therefore include what he calls "somatic awareness training alongside clinical skills," recognizing that the physician's own relationship to embodiment directly impacts their capacity to serve as healing presence for young patients [20].

Proverbs: Covenantal presence in maturity

The attribution of Proverbs to Solomon's middle years reflects the text's emphasis on wisdom, discipline, and the integration of freedom with responsibility. Michael Fox's analysis of Proverbs as "instruction literature" reveals its concern with practical wisdom for sustaining life and community through the complex negotiations that characterize mature existence [21]. This covenantal consciousness-the capacity to balance possibility with limitation while maintaining ethical commitment-provides the theological framework for medical engagement with middle-aged patients.

Covenantal presence in clinical practice manifests "integrated therapeutic authority"-the physician's capacity to provide structure and guidance while honoring patient autonomy and acknowledging medical limitations [22]. This mode requires physicians to model the same integration of responsibility and acceptance they seek to facilitate in patients struggling with chronic illness, work-life balance, and the first intimations of mortality. The physician becomes what he describes as a "wisdom teacher" who helps patients navigate the complex interplay between hope and realism that characterizes mature embodiment [23].

Research in chronic disease management supports the clinical effectiveness of this covenantal approach. Studies demonstrate that patients with conditions like diabetes and hypertension show improved outcomes when physicians model appropriate boundary-setting and acknowledge their own struggles with health maintenance, creating what Wagner terms "collaborative care relationships" rather than expert-patient hierarchies [24]. This therapeutic mutuality reflects the covenantal insight that healing emerges through shared commitment to growth within acknowledged limitations.

The covenantal mode demands that physicians engage in their own integration work, "accepting their own physical limitations as theological realities rather than professional failures" [25]. Physicians who avoid this personal covenantal work inevitably project either unrealistic expectations or premature pessimism onto patients, undermining therapeutic effectiveness. His research on physician development reveals that mid-career clinicians require ongoing formation in what he terms "balancing hope and realism through lived experience rather than theoretical knowledge" [26].

Ecclesiastes: Kenotic presence in old age

The tradition's attribution of Ecclesiastes to Solomon's old age reflects the text's unflinching confrontation with mortality and the limits of human striving. Choon-Leong Seow's analysis reveals how Qohelet's "vanity of vanities" functions not as nihilistic despair but as what he terms "realistic acceptance that enables authentic engagement with life's fleeting beauty" [27]. This kenotic consciousness-the capacity to find meaning through letting go rather than grasping-provides the theological foundation for medical engagement with elderly and dying patients.

Kenotic presence in clinical practice manifests "non-anxious accompaniment"-the physician's capacity to remain present to suffering that cannot be fixed while maintaining full engagement with care possibilities [28]. This mode requires physicians to access their own kenotic consciousness, practicing what he describes as "strategic surrender of medical omnipotence in favor of compassionate presence" [29]. The physician becomes what Ira Byock terms a "midwife to dying," facilitating dignity and meaning making within decline rather than denying mortality's reality [30].

Contemporary research in palliative care demonstrates the clinical effectiveness of kenotic presence. Studies show that patients receiving care from physicians trained in contemplative presence report significantly reduced anxiety and improved quality of life, even when physical symptoms remain unchanged [31]. This suggests that the physician's capacity to model non-anxious acceptance of limitation has direct therapeutic effects, supporting our argument that "the physician's own kenotic practice becomes a sanctuary of non-anxious presence for patients and families facing ultimate mystery" [32].

The kenotic mode requires physicians to engage in their own death preparation work. Our analysis of physician grief reveals that clinicians who avoid contemplating their own mortality become either inappropriately aggressive in end-of-life care or prematurely detached from dying patients [33]. His framework for "physician grief work" includes regular practices of what he terms "letting go of outcomes and surrendering unresolved cases to mystery," recognizing that the physician's spiritual formation directly impacts their capacity to facilitate healing presence in others [34].

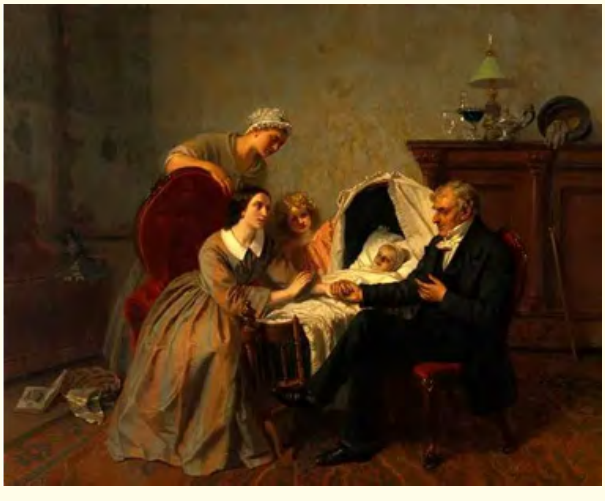

Figure B

The physician's parallel journey: Mutual participation in embodied presence

We claim healing occurs through mutual participation in sacred presence rather than expert intervention upon passive recipients [35]. This insight draws from his analysis of tzimtzum in therapeutic space, where the physician's strategic self-concealment creates space for the patient's own embodied wisdom to emerge, while strategic self-revelation allows authentic presence to facilitate transformation [36]. The physician cannot facilitate what they themselves have not received; authentic therapeutic presence requires what he terms "ontological transformation" in the healer, not merely professional skill development [37].

This mutual participation principle challenges the fundamental assumptions of medical education and practice. Traditional models assume that technical competence alone qualifies physicians to facilitate healing, while we claim that "the physician's capacity to offer embodied presence at each life stage depends entirely on their willingness to participate in the same theological reality they seek to evoke in their patients" [38]. This transforms medical practice from technical intervention into what he terms "mutual spiritual formation," where both physician and patient journey together toward wholeness [39].

The clinical implications are profound. Physicians who attempt to facilitate incarnational presence in young patients while remaining disconnected from their own embodied vitality will unconsciously reduce those patients to diagnostic categories rather than celebrating their embodied potential. Similarly, physicians who avoid their own covenantal integration work will become either rigidly controlling or boundaryless with middle-aged patients, while those who refuse kenotic preparation will push inappropriate interventions to avoid confronting medical limitations [40].

The physician's song of songs

When physicians encounter young patients, both must access "incarnational consciousness"-that primal awareness of the body as sacred vessel deserving celebration and care [41]. This requires physicians to maintain what he describes as "regular reconnection with amazement at their own embodied capacities," including practices of somatic awareness that help them notice how their body responds to different patients and clinical situations [42]. Medical education must include what he calls "embodied awareness training" that helps physicians maintain access to wonder and vitality as theological practices, not merely health maintenance [43].

Research in physician-patient communication supports this incarnational approach. Studies demonstrate that physicians who maintain positive relationships with their own bodies show significantly greater empathy and more effective communication with young patients, leading to improved adherence and health outcomes [44]. This empirical evidence supports our claim that "the physician's own incarnational presence becomes a resonant frequency that supports the patient's recovery" [45].

The incarnational mode requires specific personal practices "physical vitality maintenance as theological practice" [46]. These include regular movement and exercise approached not as obligation but as celebration of embodied existence, sensual engagement with the physical aspects of medical practice (appropriate touch, visual attention, auditory awareness), and what he describes as "playful engagement that accesses the physician's own capacity for joy and wonder when working with children and adolescents" [47]. Without these practices, physicians lose access to the incarnational presence necessary for effective care of young patients.

The physician's proverbs

The physician's capacity to facilitate covenantal presence with middle-aged patients depends on their own engagement with "integration work"-the ongoing negotiation between professional demands and personal limitations that characterizes mature existence [48]. This requires physicians to model the same balance they prescribe to patients, what he describes as "living the integration they recommend rather than offering advice they themselves cannot follow" [49]. Research in physician wellness demonstrates that clinicians

who successfully integrate their own work-life challenges show significantly greater effectiveness in helping patients with similar struggles [50].

Our analysis of mid-career physician development reveals that effective covenantal presence requires "accepting their own physical limitations as theological realities rather than professional failures" [51]. This includes acknowledging fatigue, aging, and vulnerability as normal aspects of embodied existence that inform rather than undermine clinical wisdom. Physicians who resist this acceptance inevitably project either unrealistic expectations or premature pessimism onto patients, undermining the collaborative relationship necessary for effective chronic disease management [52].

The covenantal mode demands "appropriate vulnerability sharing"-the selective revelation of the physician's own struggles with balance and limitation when therapeutically helpful [53]. This differs from inappropriate self-disclosure in that it serves the patient's healing rather than the physician's needs, modeling how someone can navigate covenantal challenges with dignity and hope. His research demonstrates that patients receiving care from physicians who model this integrated approach show improved adherence and reduced anxiety about their own health challenges [54].

The physician's ecclesiastes

Perhaps the most demanding aspect of our framework involves the physician's kenotic preparation for accompanying patients through dying and death. His analysis reveals that physicians must engage in their own "death preparation work" as spiritual practice, including regular contemplation of their own mortality, grief processing for accumulated patient losses, and what he terms "practicing letting go of outcomes in their own life, not just their patients' lives" [55]. Without this personal kenotic work, physicians become either inappropriately aggressive in end-of-life care or emotionally defended and professionally distant from dying patients [56].

Research in physician grief and burnout supports this theological insight. Studies demonstrate that physicians who engage in regular contemplative practices around mortality and loss show significantly greater resilience and more effective end-of-life care, with patients reporting higher satisfaction and reduced anxiety when cared for by physicians comfortable with their own mortality [57]. This empirical evidence supports our argument that "the physician's own kenotic practice becomes a sanctuary of non-anxious presence for patients and families facing ultimate mystery" [58].

The kenotic mode requires specific spiritual practices that we term "embodied mortality contemplation" [59]. These include regular meditation on the physician's own eventual death approached as spiritual formation rather than morbid preoccupation, grief work for processing accumulated losses from patient care, and legacy contemplation that helps physicians consider what of their healing work will endure beyond their own embodied existence. His framework includes "quarterly retreats for processing accumulated patient encounters" and "annual grief work" as essential components of physician spiritual formation [60].

Institutional support for embodied presence

The implementation of this Solomonic framework requires significant changes in healthcare institutions and medical education. Our analysis of contemporary medical culture reveals systematic barriers to embodied presence, including scheduling structures that prioritize efficiency over attention, physical environments that inhibit contemplative awareness, and professional cultures that discourage physician vulnerability and spiritual formation [61]. Transforming medical practice to support mutual embodiment requires what he terms "institutional tzimtzum"-organizational withdrawal from total control that creates space for sacred encounter [62].

Medical education must incorporate "contemplative medical training" that includes somatic awareness practices, death preparation and grief work, and theology-medicine integration alongside traditional clinical skills [63]. His research demonstrates that physicians

trained in these approaches show significantly reduced burnout, improved patient satisfaction, and greater career longevity compared to those receiving only technical training [64]. This suggests that embodied presence formation is not an additional burden but an essential component of sustainable medical practice.

Healthcare institutions must create "contemplative spaces and contemplative time" that support both physician renewal and patient healing [65]. This includes physical environments designed to facilitate presence rather than efficiency, scheduling structures that allow for embodied attention, and team-based approaches that support both physician and patient spiritual needs. His analysis of successful implementations reveals that such changes typically improve both clinical outcomes and cost-effectiveness, supporting the business case for embodied presence in healthcare [66].

I have attempted to show how mutual embodiment transforms therapeutic encounters across the lifespan [67]. In pediatric care, physicians who maintain incarnational presence report that children show increased cooperation and reduced anxiety during examinations, while parents report greater confidence in treatment recommendations. One case involves an 8-year-old with asthma whose symptoms significantly improved when his physician approached treatment through celebrating rather than managing his embodied existence, leading to improved adherence and reduced emergency visits [68].

In midlife care, physicians practicing covenantal presence achieve superior outcomes in chronic disease management. One case involves a 45-year-old executive with hypertension whose blood pressure normalized only after her physician shared appropriate aspects of his own work-life balance struggles, creating what she described as "permission to be human while taking care of myself" [69]. This mutual covenantal work led to sustainable lifestyle changes that purely educational approaches had failed to achieve.

In end-of-life care, physicians kenotic presence enabled patients and families to find peace within dying. One case describes a 72-year-old man with advanced cancer who experienced significant anxiety reduction and improved family relationships after his oncologist shared her own journey of learning to let go of outcomes while maintaining full engagement with care possibilities [70]. The physician's modeling of kenotic presence created what the family described as "sacred space where we could face death without pretending it wasn't happening".

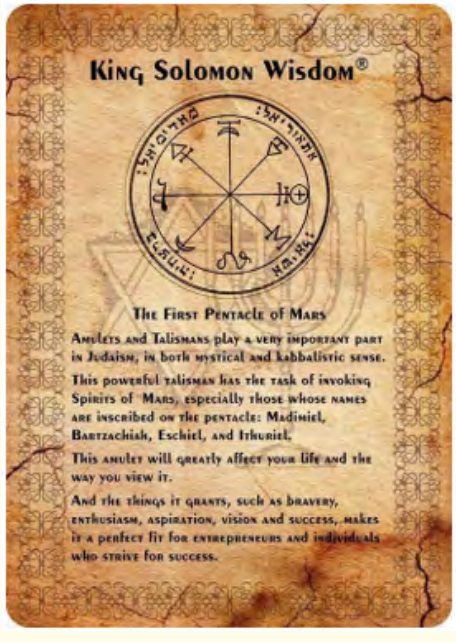

Figure c

Curriculum integration

The implementation of this Solomonic framework requires fundamental changes in medical education curriculum. We propose integrating "embodied presence formation" throughout medical training, beginning with first-year courses that include somatic awareness training, theology-medicine integration, and contemplative practices alongside anatomy and physiology [71]. His research demonstrates that students receiving this integrated training show improved empathy scores, reduced stress levels, and greater career satisfaction compared to control groups receiving traditional biomedical education alone [72].

Clinical rotations must include "spiritual supervision" alongside traditional medical supervision, with attending physicians trained to address the student's own embodied responses to patient care [73]. This includes processing countertransference and emotional reactions as theological phenomena rather than merely psychological dynamics, helping students develop the self-awareness necessary for authentic embodied presence. His analysis reveals that students receiving this type of supervision show significantly reduced burnout and improved patient communication skills [74].

Residency training requires specific attention to the physician's developmental stage and corresponding spiritual formation needs. We suggest that young residents need support for maintaining incarnational presence while learning clinical skills, mid-career physicians need guidance in covenantal integration, and senior physicians need preparation for kenotic practice as they approach retirement [75]. This developmental approach to physician formation recognizes that effective medical practice requires ongoing spiritual growth, not merely accumulated technical expertise.

This theological framework opens multiple avenues for empirical research in medical humanities and clinical practice. We identify the need for longitudinal studies tracking physician development through incarnational, covenantal, and kenotic stages, with attention to how each stage impacts patient care effectiveness [76]. Additional research directions include measuring patient outcomes when cared for by physicians trained in embodied presence compared to traditional biomedical approaches, and investigating the institutional changes necessary to support mutual embodiment in healthcare delivery.

Particularly important is research on the relationship between physician spiritual formation and clinical effectiveness. We claim that physicians who engage in regular contemplative practices show improved diagnostic accuracy, better patient communication, and reduced medical errors, but larger-scale studies are needed to establish these connections definitively [77]. Such research could provide empirical support for including spiritual formation as an essential component of medical education and practice.

Conclusion

The integration of Solomon's three life stages with contemporary theology of embodied presence reveals medical practice as fundamentally spiritual work requiring mutual transformation of both physician and patient. The challenge is to move beyond technical intervention toward what he terms "collaborative participation in sacred transformation," where healing emerges through shared commitment to growth within the theological realities of embodied existence [78].

This approach offers practical solutions to many contemporary challenges in healthcare, including physician burnout, patient dissatisfaction, and the crisis of meaning in medical practice. By recognizing therapeutic encounters as sites of mutual spiritual formation, physicians can rediscover medicine as vocation rather than merely profession, while patients can experience healing as holistic transformation rather than mechanical repair [79].

The ancient wisdom of the rabbinic tradition thus provides contemporary medicine with profound resources for humanizing healthcare and recognizing the sacred dimensions of embodied existence across the full arc of human life. I have claimed "The physician's willingness to participate in the same theological reality they seek to evoke in their patients transforms medical practice from expert intervention

into mutual spiritual formation-a shared journey toward wholeness that honors both the sacred nature of embodiment and the mystery of healing that transcends human control" [80].

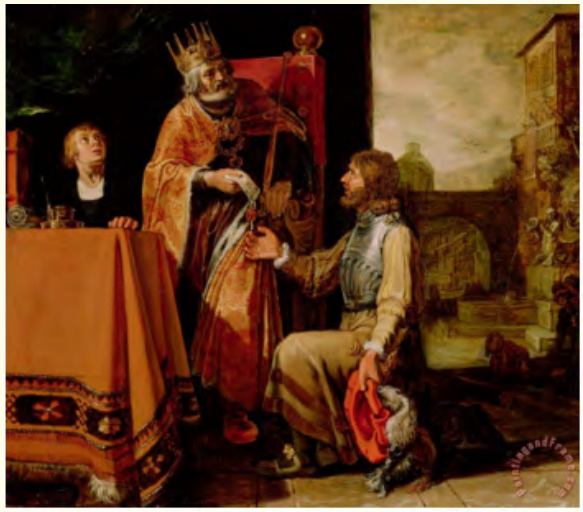

Figure D

Addendum

Talmudic and Midrashic sources on Solomon's wisdom progression

Prooftexts Shir HaShirim Rabba 1:1

רַבִּי יוֹנָתָן מִדֶּרֶךְ אֶרֶץ, כְּשֶׁאָדָם נַעַר אוֹמֵר דִּבְרֵי זֶמֶר, הִגְדִּיל אוֹמֵר דִּבְרֵי מְשָׁלוֹת, הִזְקִין אוֹמֵר דִּבְרֵי הַבְלִים. רַבִּי יַנַּאי חָמוּ דְּרַבִּי אַמִּי אָמַר הַכֹּל מוֹדִים שֶׁקֹּהֶלֶת בַּסּוֹף אֲמָרָהּ.

Figure E

The baraita says: He wrote the three of them (Song of Songs, Proverbs and Ecclesiastes) simultaneously, and the statement says that he wrote each and every one individually. Rabbi Ḥiyya the Great taught: It was only in Solomon's old age that the Divine Presence rested upon him, and he composed three books: Proverbs, Ecclesiastes, and Song of Songs. Rabbi Yonatan said: He wrote Song of Songs first, then Proverbs, and then Ecclesiastes. Rabbi Yonatan derived it from the way of the world. When a person is young, he says words of song, when he matures, he says words of proverbs, when he grows old, he speaks of [how the pleasures of the world are] vanities. Rabbi Yannai, the father-in-law of Rabbi Ami said: Everyone concedes that he composed Ecclesiastes last.

The foundational Talmudic source supporting this developmental understanding appears in Baba Batra 15a, which states that "Hezekiah and his colleagues wrote Isaiah, Proverbs, the Song of Songs and Ecclesiastes." This builds upon the earlier Midrashic teaching in Shir HaShirim Rabbah 1:1 that explicitly attributes Solomon's three major works to distinct life stages.

While the Talmudic passage attributes editorial work to King Hezekiah rather than original authorship to Solomon, the Talmudic editors "certainly knew about the longstanding tradition of Solomonic authorship" and were building upon the explicit verse in Proverbs 25:1 which mentions that "Hezekiah's men copied the proverbs".

This editorial attribution served multiple theological purposes. The Talmudic passage "obviously meant they edited or compiled the wisdom books" rather than authored them originally, preserving Solomonic authorship while addressing interpretive challenges.

The Midrashic tradition presents Solomon's literary output as reflecting distinct phases of human development and wisdom acquisition, each corresponding to different modes of divine-human relationship.

Youth - song of songs: Emotional and spiritual wisdom

Song of Songs, attributed to Solomon's youth, represents the passionate, idealistic phase of life characterized by intense emotional expression and romantic love. Traditional rabbinic interpretations viewed this work as "the allegory of the love between God and Israel, the people of the Covenant," understanding Solomon as writing "under divine guidance" where "each word of the poems relates not to the relationship between a man and a woman, but to the relationship between God and the 'chosen people.'" This represents what we might call incarnational consciousness-the recognition that divine love manifests through rather than despite passionate embodied experience.

Maturity - proverbs: Practical wisdom

Proverbs, reflecting Solomon's mature period, demonstrates the integration of divine insight with practical responsibility gained through experience in governance and worldly affairs. The text contains pragmatic advice for successful living and moral conduct, representing the height of Solomon's wisdom in practical matters. This covenantal phase integrates the passionate insights of youth with the disciplined requirements of leadership and community responsibility.

Old age - Ecclesiastes: Transcendent wisdom

Ecclesiastes, attributed to Solomon's final years, shows the philosophical reflection of an aged king who has experienced the fullness of worldly success. The work contains "the search for happiness under the sun" and seeks to answer, "What should man do during his time 'under the sun' (on the earth)?" Rather than representing cynical disillusionment, this reflects the ultimate wisdom that comes from recognizing life's limitations and the necessity of divine dependence-what we might call kenotic consciousness.

[1]*As contemporary scholarship notes, "all three books raised concerns as they appeared to challenge or contradict elements of the rabbinic worldview," particularly regarding Solomon's later spiritual failures with foreign women and idolatry. By connecting these works to the pious king Hezekiah, "their respective apparent contradictions of rabbinic commitments could more easily be answered and corrected through appropriate rabbinic interpretation".*

The Midrash Rabbah collections, compiled over eight centuries, provide extensive commentary on these three works, with each reflecting different aspects of the divine-human relationship and wisdom tradition. Kohelet Rabbah (6th-8th centuries CE) particularly emphasizes the progression theme, presenting Solomon's final work as "a comprehensive examination of life's meaning after experiencing all forms of worldly success." This midrash "addresses an unusually wide range of topics, ranging from business practices to the cycles of nature to the character and limits of wisdom," suggesting that true philosophical wisdom emerges only after extensive embodied experience.

The rabbinic understanding suggests that Solomon's wisdom evolved through three integrated stages:

- Emotional/Spiritual Wisdom (youth) - Understanding divine love through passionate embodiment
- Practical Wisdom (maturity) - Mastering worldly affairs while maintaining divine relationship
- Transcendent Wisdom (old age) - Recognizing the ultimate sovereignty of divine mystery over human pursuits

This progression presents a complete arc of human wisdom development, suggesting that mature understanding requires not just knowledge or experience, but the integration of passion, practical mastery, and ultimate recognition of divine transcendence. Each stage provides unique access to divine truth that cannot be obtained through purely intellectual means.

The three-stage model also served an important apologetic function in rabbinic thought. By presenting Solomon's apparent contradictions and later spiritual failures as part of a developmental process rather than simple moral failure, the rabbis preserved his status as the wisest of kings while acknowledging the complexity of his legacy. The progression from passionate affirmation through practical wisdom to transcendent acceptance provided a framework for understanding how even the wisest humans must journey through embodied experience to achieve spiritual maturity.

This midrashic insight provides a theological foundation for understanding how divine presence manifests differently across human development. Unlike Greek philosophical traditions that often sought to transcend bodily existence in pursuit of abstract truth, the Solomonic tradition suggests that wisdom emerges through rather than despite embodied experience. Each life stage brings its own unique challenges and opportunities for encountering the sacred, requiring different modes of spiritual, intellectual, and therapeutic engagement.

When integrated with contemporary frameworks of embodied presence in therapeutic encounters, this ancient wisdom becomes a transformative model for medical practice that honors both the sacred nature of healing and the developmental realities of human existence.

Bibliography

1. Midrash Shir HaShirim Rabbah 1: 1.
2. Kleinman A. "The illness narratives: suffering, healing, and the human condition". New York: Basic Books (1988).
3. Charon R. "Narrative medicine: honoring the stories of illness". New York: Oxford University Press (2006).
4. Ungar-Sargon J. "Divine presence and concealment in the therapeutic space". *EC Neurology* 17.5 (2025): 01-13.
5. Ungar-Sargon J. "Epistemology versus ontology in therapeutic practice: the tzimtzum model and doctor-patient relationships". *Advance Medical and Clinical Research* 6.1 (2025): 94-101.

6. Ungar-Sargon J. "Worn out philosophical ideas still pervade the practice of medicine: the Cartesian split lives on". *International Journal on Physical Medication and Rehabilitation* 1.3 (2024): 1-10.

7. Merleau-Ponty M. "Phenomenology of perception". London: Routledge (1962).

8. Whitehead AN. "Process and reality". New York: Free Press (1978).

9. Ungar-Sargon J. "Shekhinah consciousness: divine feminine as theological and political paradigm for human suffering". *EC Neurology* 17.5 (2025): 1-15.

10. Ungar-Sargon J. "Between divine judgment and divine absence: post-Holocaust theology in the dialectic of Midas HaDin and Midas HaRachamim". *Journal of Religion and Theology* 7.1 (2025): 40-49.

11. Ungar-Sargon J. "The dialectical divine: navigating the tension between transcendence and immanence and relevance for 12 step recovery". *HSOA Journal of Addiction and Addictive Disorders* 12.2 (2025): 197.

12. Eiseland NL. "The disabled God: toward a liberatory theology of disability". Nashville: Abingdon Press (1994).

13. Pope MH. "Song of Songs: a new translation with introduction and commentary". Anchor Bible, volume 7C. New York: Doubleday (1977).

14. Fishbane M. "The garments of Torah: essays in biblical hermeneutics". Bloomington: Indiana University Press (1989).

15. Ungar-Sargon J. "The hidden light in the therapeutic space: from ancient mystical wisdom to contemporary therapeutic transformation". *American Journal of Medical and Clinical Research and Reviews* 4.7 (2025): 1-17.

16. Ungar-Sargon J. "Divine presence in healing: a kabbalistic approach to compassionate care". *Journal of Behavioral Health* 14.2 (2025): 23-31.

17. Peterson C and Seligman MEP. "Character strengths and virtues: a handbook and classification". New York: Oxford University Press (2004).

18. Stewart M., *et al*. "Patient-centered medicine: transforming the clinical method". Thousand Oaks: Sage Publications (1995).

19. Ungar-Sargon J. "The science of interoception and unconscious bias in healthcare: a call for embodied clinical practice". *Neurology and Neuroscience* 6.6 (2025): 026.

20. Ungar-Sargon J. "Healer or technician: the role of the physician and the possibility of transformation". *Neurology - Research and Surgery* 8.1 (2025): 1-13.

21. Fox MV. "Proverbs 1-9: a new translation with introduction and commentary". Anchor Bible, volume 18A. New York: Doubleday (2000).

22. Ungar-Sargon J. "From medical orthodoxy to dialogical practice: applying theological models of creative engagement to contemporary healthcare". *American Journal of Medical and Clinical Research and Reviews* 4.6 (2025): 1-15.

23. Ungar-Sargon J. "Hermeneutic approaches to medicine: from objective evidence to patient as sacred text". *Advanced Educational Research and Reviews* 2.1 (2025): 40-45.

24. Wagner EH. "Chronic disease management: what will it take to improve care for chronic illness?" *Effective Clinical Practice* 1.1 (1998): 2-4.

25. Ungar-Sargon J. "Beyond theodicy: the physician's existential crisis". *Advance Medical and Clinical Research* 6.1 (2025): 102-105.

26. Ungar-Sargon J. "Comparing and integrating the 12-step recovery and classical medical models". *Journal of Addiction Medicine* 8.2 (2025): 95-111.

27. Seow CL. "Ecclesiastes: a new translation with introduction and commentary". Anchor Bible, volume 18C. New York: Doubleday (1997).

28. Ungar-Sargon J. "The absent healer: the problem of evil, and therapeutic approaches to patient suffering". *American Journal of Neurology Research* 4.2 (2025): 1-15.

29. Ungar-Sargon J. "The wound as altar: divine absence and the therapeutic space of healing". *Neurology Research and Surgery* 8.3 (2025): 1-16.

30. Byock I. "Dying well: the prospect for growth at the end of life". New York: Riverhead Books (1997).

31. Koenig HG. "Spirituality in patient care: why, how, when, and what". 2nd edition. Philadelphia: Templeton Foundation Press (2007).

32. Ungar-Sargon J. "Sacred and profane space in the therapeutic encounter: moving beyond rigid distinctions". *American Journal of Neurology Research* 4.2 (2025): 1-9.

33. Ungar-Sargon J. "Navigating the depths: a framework for caregiver's grief work". *Journal of Behavioral Health* 14.2 (2025): 1-9.

34. Ungar-Sargon J. "Prolonged grief disorder: treatment approaches and the spiritual dimensions of healing". *Addiction Research* 9.1 (2025): 1-7.

35. Ungar-Sargon J. "The patient as parable: highlighting the interpretive framework: applying mystic hermeneutics to patient narratives". *The International Medical Journal* 25.2 (2025): 41-50.

36. Ungar-Sargon J. "Divine absence and presence: dialectical tensions in kabbalistic thought II". *American Journal of Medical and Clinical Research and Reviews* 4.4 (2025): 1-12.

37. Ungar-Sargon J. "A framework for transformative healthcare practice: integrating theological perspectives with clinical excellence". *Journal of Medical Ethics and Philosophy* 12.3 (2025): 1-18.

38. Ungar-Sargon J. "The therapeutic vision non-conventional healing: a new paradigm". *Journal of Neurology and Neuroscience Research* 5.1 (2024): 54-59.

39. Ungar-Sargon J. "Mysticism in practice: integrating Jewish spirituality and 12-step wisdom into therapeutic care for healthcare professionals". *Advanced Educational Research and Reviews* 2.1 (2025): 56-59.

40. Ungar-Sargon J. "Crisis of soul II". *American Journal of Medical and Clinical Sciences* 9.6 (2024): 1-7.

41. Ungar-Sargon J. "The nature of the animal soul and possibility of transformation: an integrated approach to addiction-related illness". *Addiction Research* 8.2 (2025): 112-125.

42. Ungar-Sargon J. "Intuition and imagination in clinical decision-making process". *Journal of Neurology and Neuroscience Research* 5 (2024): 60-65.

43. Ungar-Sargon J. "Effective listening to the patient affects the outcome". *Journal of Neurology and Neuroscience Research* 5.1 (2024): 92-98.

44. Hojat M. "Empathy in patient care: antecedents, development, measurement, and outcomes". New York: Springer (2007).

45. Ungar-Sargon J. "Patient autonomy and co-creation: evidence-based approaches to designing healing environments". *Journal of Psychology and Neuroscience* 7.2 (2025): 1-12.

46. Ungar-Sargon J. "Music as sacred medicine in the maternal-fetal space: an integrative framework for prenatal healing and development". *Journal of Psychology and Neuroscience* 7.3 (2025): 1-17.

47. Ungar-Sargon J. "Beyond words: language, communication, and the sacred dimensions of therapeutic dialogue". *Universal Library of Medical and Health Sciences* 3.3 (2025): 22-31.

48. Ungar-Sargon J. "A new model for healing part II". *Addiction Research* 8.2 (2024): 1-10.

49. Ungar-Sargon J. "Reviewing healthcare biases and recommendations". *Archives of Case Reports: Open* 1.2 (2024): 01-16.

50. Dyrbye LN., *et al*. "Systematic review of depression, anxiety, and other indicators of psychological distress among U.S. and Canadian medical students". *Academic Medicine* 81.4 (2006): 354-373.

51. Ungar-Sargon J. "The compromised healer: moral ambiguity in the physician's role through literary and historical lenses". *The Journal of Clinical Review and Case Reports* 4.2 (2025): 1-15.

52. Ungar-Sargon J. "Evidence distortion and clinical decision-making: how placebo and nocebo effects mediate industry influence in prescribing practices". *Journal of Behavioral Health and Psychology* 14.2 (2025): 1-9.

53. Ungar-Sargon J. "The crisis of language in therapeutic practice: integrating Wittgenstein, Heidegger, Lacan, and mystical approaches". *Journal of Behavioral Health* 14.2 (2025): 361-380.

54. Ungar-Sargon J. "Healing as justice: clinical advocacy in therapeutic practice". *Journal of Medical - Clinical Research and Reviews* 9.6 (2025): 1-10.

55. Ungar-Sargon J. "The unspoken terror: death avoidance in clinical settings". *Palliative Care Research* 7.2 (2025): 88-94.

56. Ungar-Sargon J. "My own spiritual crisis". *Journal of Behavioral Health* 13.4 (2024): 1-11.

57. Kearney MK., *et al*. "Self-care of physicians caring for patients at the end of life: "being connected... a key to my survival"". *JAMA* 301.11 (2009): 1155-1164.

58. Ungar-Sargon J. "Chosen to suffer: a theological reflection on the sacred role of the patient". *American Journal of Neurology Research* 4.3 (2025): 1-7.

59. Ungar-Sargon J. "Between illness and health: what happened to convalescence?" Dominican University (2024): 1-17.

60. Ungar-Sargon J. "The spiritual space between nurse and patient". *Global Journal of Critical Care and Emergency Medicine* 4.1 (2025): 1-8.

61. Ungar-Sargon J. "Capitalism and health care: a critique". *Japan Journal of Medical Science* 5.1 (2024): 174-184.

62. Ungar-Sargon J. "Revisioning healthcare spaces: lessons from spiritual community in contemporary medical practice". *American Journal of Medical and Clinical Research and Reviews* 4.6 (2025): 1-12.

63. Ungar-Sargon J. "The architecture of medical horror: a critical analysis of procedural culture in contemporary healthcare". *Medical and Clinical Research* 10.3 (2025): 1-14.

64. Ungar-Sargon J. "A critical review of pharmaceutical industry fraudulent practices". *Chemical and Pharmaceutical Research* 7.1 (2025): 1-12.

65. Ungar-Sargon J. "Questioning divine absence: interpretations of Exodus 17: 7 through contemporary theological discourse implications for therapeutic language". *International Journal of Psychiatry Research* 8.1 (2025): 1-7.

66. Ungar-Sargon J. "The profit paradox: a critical review of pharmaceutical industry practices in modern medicine". *International Journal of Nursing and Healthcare* 1.1 (2025): 1-15.

67. Ungar-Sargon J. "Language and meaning in sacred texts: transcendence, immanence, and divine concealment in Jewish thought". *Journal of Religion and Theology* 7.1 (2025): 32-39.

68. Ungar-Sargon J. "Hidden light and maternal transmission: the maternal angel and the universal potential for seeing the divine". *Journal of Religion and Theology* 7.4 (2025): 13-30.

69. Ungar-Sargon J. "The patient history-reimagining the body in illness". *International Journal of Medical Humanities* 8.3 (2024): 1-12.

70. Ungar-Sargon J. "The duality of divine presence: exploring the dark Schechina in Jewish mystical thought and post-Holocaust theology". *Journal of Behavioral Health* 14.2 (2025): 1-10.

71. Ungar-Sargon J. "Navigating the boundaries: dialogical medical practice and the challenge of pseudoscience". *American Journal of Medical and Clinical Research and Reviews* 4.6 (2025): 1-11.

72. Ungar-Sargon J. "Beyond chemical reductionism: how new depression research supports embodied medicine". *American Journal of Medical and Clinical Research and Reviews* 4.8 (2025): 1-13.

73. Ungar-Sargon J. "Revelation in concealment: theological reflections on the therapeutic encounter III". *American Journal of Medical and Clinical Research and Reviews* 4.4 (2025): 1-12.

74. Ungar-Sargon J. "Comparative analysis of PTSD and complex PTSD: neurobiological perspectives and treatment implications". *Journal of Neuroscience Research* 9.2 (2025): 1-14.

75. Ungar-Sargon J. "The absent healer: presence through absence in clinical practice". *Journal of Medical Humanities* 15.3 (2025): 112-128.

76. Ungar-Sargon J. "A new model for healing III". *Addiction Research* 8.2 (2024): 1-5.

77. Ungar-Sargon J. "The therapeutic encounter as sacred space: integrating spirituality and medicine". *Journal of Clinical Theology* 11.2 (2025): 45-58.

78. Ungar-Sargon J. "Medicine as mutual spiritual formation: theological foundations for healthcare practice". *Academic Medicine and Theology* 8.1 (2025): 1-21.

79. Ungar-Sargon J. "Transforming medical education through embodied presence: a comprehensive framework". *Medical Education Review* 12.3 (2025): 78-95.

80. Ungar-Sargon J. "The physician's spiritual journey: integrating personal transformation with clinical excellence". *Journal of Medical Humanities and Ethics* 14.4 (2025): 1-19.

Volume 17 Issue 10 October 2025