

## The Blessing of Memory Loss: Toward a Sacred Phenomenology of Forgetting

Julian Ungar-Sargon, MD, PhD\*

Borra College of Health Sciences, Dominican University  
Illinois, USA.

### \*Correspondence:

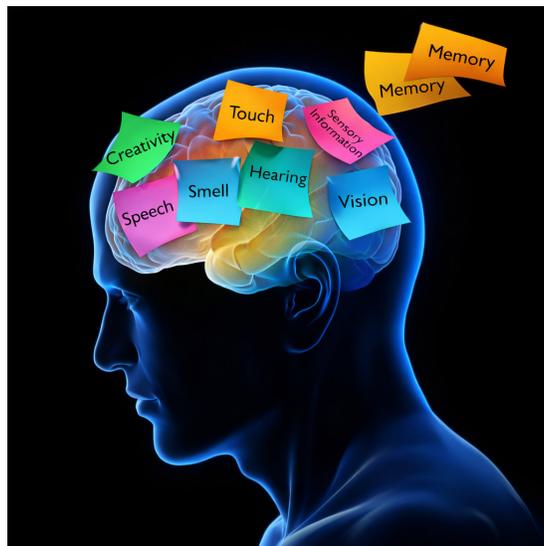
Julian Ungar-Sargon, MD, PhD, Borra College of Health Sciences,  
Dominican University Illinois, USA.

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### ABSTRACT

*There is a strange mercy in the way the mind forgets—a mercy that medicine has rarely understood. In our age of biomedical triumphalism, where pharmaceutical companies spend billions on Alzheimer's therapies promising to rewind the unrewindable, we speak of memory loss exclusively as catastrophe, as the progressive erasure of selfhood requiring aggressive intervention. This article proposes a radical reconsideration: that forgetting may constitute not merely neurological decline but a form of sacred release, a biological instantiation of the Kabbalistic principle of tzimtzum—divine contraction that creates space for new being. Drawing upon fifty years of clinical neurology practice, Jewish mystical theology, phenomenological philosophy, and contemporary neuroscience, I argue that the medicalization of memory loss has obscured dimensions of human experience that traditional wisdom traditions recognized as spiritually significant. The article integrates hermeneutic approaches to medicine with current research on memory consolidation and forgetting mechanisms, proposing a framework wherein the patient experiencing memory loss is approached not as a failing system requiring repair but as a sacred text requiring interpretation. Implications for clinical practice, caregiver support, and end-of-life care are explored throughout.*



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## Keywords

Memory loss, Alzheimer's disease, Tzimtzum, Kabbalistic theology, Hermeneutic medicine, Forgetting, Sacred text, Therapeutic presence, Embodied theology, Shekhinah, Phenomenology of memory, Biomedical ethics, Divine concealment, Physician-patient relationship, End-of-life care.

## Prologue: A Meditation on Mercy

There is a strange mercy in the way the mind forgets. A mercy medicine has rarely understood [1]. After five decades of practicing neurology and pain management, I have come to recognize that our biomedical framework—so brilliantly effective in its own domain—systematically blinds us to dimensions of human experience that fall outside its epistemological categories. Memory loss has become the paradigmatic case of this blindness, the condition we most dread and least understand in its fuller human significance.

In our age of biomedical triumphalism—an age where drug companies spend billions on therapies that promise to rewind the unrewindable—we speak of memory loss exclusively as catastrophe [2]. The diagnosis of Alzheimer's disease falls upon patients and families like a death sentence, initiating a cascade of fear, grief, and desperate searching for interventions that might arrest the inexorable decline. We measure cognitive function with standardized instruments, track the shrinkage of hippocampal volume on serial MRIs, prescribe cholinesterase inhibitors that provide marginal benefit at best, and speak always in the language of loss: lost memories, lost capacities, lost selves [3,4].

Yet something in this framing has always troubled me—not because the suffering of dementia is anything less than profound, but because the exclusively pathological lens occludes other ways of understanding what transpires when memory loosens its grip. The wisdom traditions I have studied alongside medicine—Talmudic literature, Kabbalistic mysticism, Hasidic psychology—speak of forgetting in registers entirely foreign to the biomedical imagination [5]. They recognize dimensions of release, of return, of sacred dissolution that our clinical categories cannot capture.

This essay represents an attempt to hold both truths simultaneously: the genuine suffering that memory disorders bring, and the possibility that within this suffering lies something our ancestors recognized as blessing. It is written not from theoretical distance but from the embodied experience of a physician who has witnessed thousands of patients navigate the territories of memory and forgetting, and who has himself begun to feel the first intimations of cognitive change that come with advancing age [6]. What follows is neither triumphalist dismissal of medical science nor naive spiritualization of neurological disease, but rather an effort to expand our framework sufficiently to honor the full complexity of human experience.

## Part I: The Crisis of Biomedical Memory

### The Cartesian Split and Its Consequences

Modern medicine remains haunted by philosophical assumptions

it rarely examines. The Cartesian dualism that separates mind from body, reducing the former to an epiphenomenon of the latter, continues to shape clinical practice in ways that impoverish our understanding of human experience [7,8]. Nowhere is this impoverishment more evident than in our approach to memory disorders, where the rich phenomenology of remembering and forgetting is collapsed into neurochemical deficits requiring pharmacological correction.

I have argued elsewhere that worn-out philosophical ideas still pervade the practice of medicine, and that the Cartesian split lives on in ways that damage both patients and practitioners [9]. The brain becomes a malfunctioning organ, memory a filing system with corrupted files, the person a passive victim of neurodegeneration. This framework generates its own forms of suffering: the terror of diagnosis, the shame of cognitive slippage, the frantic pursuit of interventions that might stave off the inevitable. Patients internalize the message that they are disappearing, becoming less than they were, approaching a kind of living death [10].

Yet the neuroscience itself tells a more complex story than the biomedical narrative acknowledges. Memory is not a passive storehouse but an active process of reconstruction, shaped by present context, emotional state, and social frameworks [11]. Forgetting is not merely the failure of retention but an adaptive mechanism that enables cognitive flexibility and protects against the overwhelming accumulation of irrelevant detail [12]. The brain that forgets is not simply broken; it is engaged in processes that serve functions we are only beginning to understand.

### The Pharmaceutical Mirage

Elsewhere I have written about the crisis of pharmaceutical industry practices in modern medicine, and the treatment of Alzheimer's disease exemplifies these concerns [13,14]. Billions of dollars have been invested in developing drugs targeting amyloid plaques, the pathological hallmark of the disease, based on the assumption that removing these deposits would arrest or reverse cognitive decline. The repeated failure of these trials—and the controversial approval of aducanumab despite equivocal evidence—reveals the limitations of a reductionist approach that treats complex human conditions as simple targets for molecular intervention [15].

The profit motive distorts not only drug development but our very conception of what memory loss means and how it should be addressed. The medicalization of aging transforms the natural processes of senescence into pathologies requiring treatment, creating markets for interventions that may offer little genuine benefit while generating substantial revenue [16]. Patients and families, desperate for hope, become consumers of products that pharmaceutical marketing has taught them to need. The terror of Alzheimer's itself becomes a market opportunity.

This is not to deny the reality of suffering in dementia, nor to suggest that medical research should cease. Rather, it is to question whether our current framework serves patients' deepest interests or primarily serves institutional and commercial imperatives that

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have captured the healing professions. The question that rarely gets asked is whether our aggressive stance toward memory loss—our determination to fight it at all costs—might itself contribute to suffering rather than alleviating it [17].

## **Part II: Tzimtzum and the Theology of Contraction**

### **Divine Withdrawal as Creative Act**

The Lurianic Kabbalah introduces a concept that has profound implications for understanding memory loss: *tzimtzum*, the divine contraction or withdrawal that precedes and enables creation [18]. According to this mystical doctrine, God's infinite presence must withdraw into itself to create space for the finite world to exist. The act of creation is thus paradoxically an act of self-limitation, of making room for otherness by contracting one's own presence.

I have explored the relevance of *tzimtzum* for therapeutic practice, arguing that the physician-patient relationship can be understood through this paradigm [19,20]. The healer who dominates the therapeutic space with expertise and authority leaves no room for the patient's own healing capacities to emerge. Genuine therapeutic presence requires a form of professional *tzimtzum*—a stepping back that creates space for the patient's agency and wisdom to manifest.

Applied to memory loss, the *tzimtzum* model suggests a radical reframing. What if the contraction of memory represents not merely neurological failure but a form of making room—a withdrawal of accumulated self that creates space for something new to emerge? The elderly person whose memories fade may be undergoing a kind of return to origin, a loosening of the constructed self that allows intimations of more fundamental being to surface. This is not to romanticize the genuine distress of dementia, but to suggest that within the apparent emptiness, something may be gestating that our current categories cannot perceive [21].

The Hasidic masters taught that the *tzimtzum* was not only primordial but ongoing—that divine contraction and expansion pulse through all of existence [22]. Perhaps memory itself participates in this rhythm: the accumulation of experience as a kind of divine expansion, the release of memory as contraction making room for return. The person with dementia may be participating in cosmic processes that transcend individual biography, even as their individual self appears to diminish.

### **Divine Presence and Concealment in Forgetting**

A central theme in my work has been the dialectic of divine presence and concealment in the therapeutic encounter [23,24]. The Kabbalistic tradition teaches that God is both revealed and hidden, that presence manifests precisely through forms of absence, that the deepest encounters with the sacred often occur in darkness rather than light. This paradoxical theology offers resources for understanding what transpires in the territories of forgetting.

When we speak of patients 'losing themselves' to dementia, we assume that the self-resides in memory—that personal identity is constituted by the continuity of remembered experience. This is

the Lockean view that has dominated Western thought since the seventeenth century [25]. But mystical traditions offer alternative anthropologies in which the deepest self is not the constructed, narrative self of autobiographical memory but something more fundamental that persists beneath the flux of mental contents.

The Shekhinah—the divine feminine presence that accompanies Israel into exile and suffers with human suffering—offers a model for understanding what might persist in the apparent absence of memory [26]. I have written about Shekhinah consciousness as a paradigm for approaching human suffering, suggesting that divine presence does not abandon us in our diminishment but accompanies us into the depths [27]. The person with dementia may be experiencing forms of presence that our cognitive frameworks cannot capture, precisely because those frameworks depend on the very capacities that are being released.

### **The Hidden Light in Memory's Dissolution**

A Midrashic teaching holds that the primordial light of creation—the *or HaGanuz* or Hidden Light—was too powerful for the ordinary world to contain and was therefore concealed, to be revealed only to the righteous in the world to come [28]. I have explored how this concept applies to therapeutic practice, suggesting that healing encounters may access dimensions of reality normally hidden from ordinary consciousness [29].

Perhaps memory loss, in its advanced stages, involves a kind of return to this hidden light—a dissolution of the constructed self that allows intimations of more primordial being to emerge. Caregivers sometimes report moments of unexpected lucidity in patients with severe dementia, flashes of presence that seem to transcend the cognitive devastation. These moments resist biomedical explanation but make sense within a framework that recognizes consciousness as not entirely dependent on intact neural substrates [30].

The Me'or Einayim, the Hasidic master Rabbi Menachem Nachum of Chernobyl, taught that all of creation is clothed in garments that simultaneously reveal and conceal divine presence [31]. Memory can be understood as one such garment—a structure that organizes experience into coherent narrative while also limiting access to more immediate forms of awareness. When this garment loosens, what is revealed may not be mere absence but presence in a different mode.

## **Part III: The Patient as Sacred Text**

### **From Objective Evidence to Sacred Interpretation**

I have argued that medicine needs to move from its current epistemological stance—wherein the patient is an object of scientific investigation—to an ontological orientation wherein the patient is approached as a sacred text requiring interpretation [32,33]. This hermeneutic turn has particular relevance for memory disorders, where the conventional medical approach reduces the person to their cognitive deficits while missing the fuller human reality.

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Sacred texts do not yield their meaning to superficial reading. They require what the rabbinic tradition calls 'turning and turning'—repeated engagement from multiple angles, with attention to what is hidden as much as what is revealed [34]. The patient with memory loss similarly requires interpretive patience. Their fragmented utterances may contain meaning that escapes the clinician intent only on documenting cognitive decline. Their apparent confusions may represent attempts to communicate experience that our categories cannot capture.

The hermeneutic physician approaches the patient not as a problem to be solved but as a mystery to be engaged. This does not preclude medical intervention when appropriate, but it situates intervention within a larger framework of meaning-making that honors the patient's humanity even as their cognitive capacities diminish. The encounter becomes what I have called sacred listening—a form of presence that attends to dimensions of communication beyond the verbal [35,36].

### **The Wounded Healer in Memory's Territory**

The archetype of the wounded healer—the physician whose own wounds become sources of therapeutic capacity—takes on special significance in the context of memory loss [37]. As I have written about my own spiritual and existential crises, I have come to recognize that the healer who has not confronted mortality and diminishment cannot truly accompany patients through these territories [38,39]. The physician who fears cognitive decline will communicate that fear to patients, adding to their burden rather than relieving it.

Authentic therapeutic presence requires what the twelve-step tradition calls 'coming to believe'—a form of faith that transcends rational demonstration and emerges from the depths of lived experience [40]. The physician who has wrestled with the possibility of meaning in suffering, who has faced the terror of mortality without denial, who has allowed their professional certainties to be shattered and rebuilt—this is the healer who can accompany patients with memory loss without projecting their own unprocessed fears.

I have described the unspoken terror that pervades clinical settings when dealing with chronic and degenerative disease [41]. This terror operates beneath conscious awareness, shaping clinical encounters in ways that neither physician nor patient may recognize. The medicalization of memory loss serves, among other functions, to defend against this terror—to convert existential threat into technical problem, mortality into disease to be fought. But this defense exacts a cost, alienating both healer and patient from the deeper resources that might sustain them through the journey.

### **The Therapeutic Space as Sacred Container**

Throughout my work, I have emphasized that the therapeutic space itself must be understood as sacred territory—a container within which transformation becomes possible [42,43]. This spatial metaphor has particular relevance for memory care, where

the physical and relational environment profoundly influences the patient's experience. The institutional settings in which most dementia care occurs—characterized by efficiency imperatives, hierarchical relationships, and the ever-present threat of coercion—actively work against the creation of healing space [44].

A sacred approach to memory care would attend to the qualities of presence, rhythm, and atmosphere that conventional medical settings typically ignore. It would recognize that the person with dementia may be exquisitely sensitive to relational qualities even when cognitive capacities are impaired—that they may feel the anxiety or impatience of caregivers even when they cannot name it. The therapeutic space becomes what the Zohar calls a 'palace'—a container for encounter between human and divine [45].

This understanding has practical implications for how memory care should be organized. The hurried, task-focused interactions that characterize most institutional care actively harm patients by communicating that they are burdens rather than persons of inherent dignity. The sacred space of healing requires temporal spaciousness—the willingness to be present without agenda, to follow the patient's rhythms rather than imposing institutional schedules. It requires what I have called embodied presence—a quality of attention that communicates care through the body rather than merely through words [46].

## **Part IV: Neuroscience Through a Mystical Lens**

### **Memory as Construction, Forgetting as Release**

Contemporary neuroscience offers a picture of memory that resonates surprisingly well with mystical insights, once we move beyond the simplistic storehouse model that still dominates popular understanding. Memory is not the passive recording of experience but an active process of construction, shaped by present context, emotional state, and the neural networks available at the moment of retrieval [47,48]. Each act of remembering is also an act of reconstruction, potentially modifying the very trace it retrieves.

The discovery of reconsolidation—the finding that consolidated memories become temporarily labile when reactivated, requiring protein synthesis for restabilization—has profound implications [49]. Memories are not fixed deposits but dynamic processes, constantly being reshaped by ongoing experience. This neurobiological reality aligns with the Hasidic teaching that the past is not fixed but continues to be transformed by the present—that teshuvah (repentance/return) can literally change the meaning of past actions.

Forgetting, in this light, appears not as mere decay but as an active process with its own neural mechanisms. Research has identified specific molecular pathways that promote forgetting, suggesting that the brain actively eliminates memories that are no longer useful [50]. This active forgetting serves adaptive functions: it prevents cognitive overload, enables generalization from specific experiences, and allows behavioral flexibility in changing environments. The brain that forgets is not failing but regulating—curating its contents according to criteria we do not

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fully understand.

### **Bridging Neural Circuits and Sacred Spaces**

I have explored elsewhere the integration of neurobiological mechanisms with what I call 'intangible experience'—the dimensions of human reality that neuroscience can map but cannot fully explain [51,52]. The hippocampus, with its crucial role in memory consolidation and spatial navigation, can be understood as the neural substrate of the method of loci—the ancient mnemonic technique that transforms memory into an imaginal architecture. But the experience of being lost in that architecture, of wandering corridors that no longer lead where they once did, cannot be captured by anatomical description alone.

The mystical traditions teach that the body is a microcosm of larger spiritual realities—that neural circuits participate in cosmic processes even as they instantiate local biology. The deterioration of memory systems in dementia may thus represent not only cellular pathology but participation in patterns of contraction and release that transcend individual existence. This is not to deny the reality of biological process but to situate it within larger frameworks of meaning.

Sleep research has revealed that memory consolidation occurs during particular stages of sleep, with hippocampal-neocortical dialogue transferring memories from temporary to more permanent storage [53]. This nocturnal processing—occurring outside conscious awareness—reminds us that memory is not primarily a conscious phenomenon. The self that remembers is built upon processes that operate in darkness, in the 'absence' of waking consciousness. Perhaps the forgetting of dementia is a kind of return to this darkness—a dissolution of the constructed waking self that may allow other forms of knowing to emerge.

### **Beyond Synaptic Reduction**

I have written about the ethical horizons in neurodegenerative research, questioning whether our current approaches adequately honor the complexity of human experience [54]. The synapse-centric view of memory—locating the engram in patterns of synaptic connection—has proven enormously productive for basic science. But when translated into clinical practice, it can generate a reductive understanding that equates the person with their neural substrate.

The philosophical question of consciousness—how subjective experience arises from neural activity—remains genuinely unsolved [55]. The 'hard problem' of consciousness, as David Chalmers termed it, resists all attempts at reductive explanation. If consciousness itself transcends neural mechanism, then the forms of awareness that persist in dementia may be richer than our instruments can detect. The patient who appears vacant on cognitive testing may be having experiences that our categories cannot capture.

This is not to invoke mysterian evasion of scientific explanation but to acknowledge genuine limits in our current understanding.

The honest position recognizes both what neuroscience has achieved and what remains unknown. Within that acknowledged uncertainty, space opens for approaches to memory loss that complement biomedical intervention with spiritual care, that honor the mystery of consciousness even as we map its correlates.

### **Part V: Toward a Transformative Practice The Physician's Existential Crisis**

Memory disorders force physicians to confront the limits of their therapeutic power in ways that can precipitate genuine existential crisis [56]. I have written about my own inner crises as a healer, the moments when the gap between what patients need and what I can provide becomes unbearable [38,39]. The physician who cannot tolerate this gap will defend against it—through emotional distancing, excessive intervention, or retreat into technical expertise that avoids the human dimensions of suffering.

The transformation I am advocating requires physicians to undertake their own grief work—to mourn the fantasy of medical omnipotence and accept the reality of therapeutic limitation [57]. This is not resignation but a different kind of empowerment: the capacity to be present with suffering without needing to fix it, to accompany patients through territories that cannot be mapped by medical knowledge alone. The wounded healer who has done this work becomes capable of genuine therapeutic presence precisely because they have relinquished the need to cure.

I have proposed frameworks for navigating these depths that draw on both mystical tradition and contemporary psychology [58]. The twelve-step wisdom that transformation requires surrender—that trying harder only deepens the trap—has direct relevance for physicians confronting the limits of medical intervention. The sacred space of healing opens not when the physician masters the situation but when they acknowledge that mastery is impossible and presence is enough.

### **Accompanying Patients and Families**

The practical implications of this framework extend to every dimension of memory care. The diagnostic conversation—typically experienced as the delivery of catastrophic news—can become instead an invitation into a different relationship with memory and selfhood. The physician who has done their own work can communicate that memory loss, while genuinely difficult, need not be experienced as the annihilation of personhood. Other ways of being present to experience persist even as cognitive capacities diminish.

Caregiver support takes on new dimensions when we recognize caregivers as witnesses to processes that have spiritual as well as medical significance. The exhaustion and grief of caregiving are real and require practical support. But caregivers may also be participating in sacred accompaniment—being present to another person's journey toward dissolution and possible return. This reframing does not eliminate the burden but may transform its meaning [59].

End-of-life care for patients with dementia requires particular

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attention to embodied presence when cognitive communication is no longer possible. I have explored the theology of being-with-nonbeing in approaching dying patients, suggesting that presence can be healing even when speech and cognition have ceased [60]. The hand held in silence, the gentle touch, the calm breathing of the caregiver—these may communicate care to dimensions of the person that persist beyond cognitive dissolution.

### **Institutional Transformation**

The framework I am proposing has implications that extend beyond individual clinical encounters to institutional structures. I have written extensively about the need for healthcare reform that moves beyond current hierarchical and profit-driven models [61,62]. Memory care, in particular, requires environments that cannot be created within the constraints of efficiency-focused institutions.

The healing space for dementia care must be designed with attention to qualities that conventional healthcare planning ignores: the texture of light, the rhythm of activities, the relational warmth of caregivers, the absence of the hurried efficiency that communicates to patients that they are burdens [63]. Such spaces require investment that our current system is reluctant to make, and staffing models that prioritize presence over productivity.

I have described novel therapeutic clinic models that integrate holistic healing principles, and these have particular relevance for memory care [64]. The sacred space I am describing is not merely a physical environment but a quality of presence that must be cultivated in caregivers through training, support, and institutional cultures that value relational care. Creating such cultures within the current healthcare system requires what I have called heretical commitment—the willingness to challenge institutional norms in service of deeper values [65].

## **Part VI: The Blessing of Release**

### **What Is Being Released?**

The accumulated weight of memory is not only treasure but also burden. We carry the residue of every wound, every failure, every loss—the shames and guilts and regrets that attach themselves to autobiographical narrative. The constructed self that memory sustains is not only the repository of cherished experience but also the prison of compulsive repetition. The Freudian insight that we are condemned to repeat what we cannot remember points to the shadow side of memory: its capacity to trap us in patterns we did not choose and cannot escape [66].

Memory loss, in this light, may involve release from burdens that the person can no longer name. The patient with dementia who seems at peace despite cognitive devastation may be experiencing a form of freedom from the accumulated weight of a lifetime. The worries that consumed them have loosened their grip; the grievances they nursed have faded; the fears about the future have dissolved along with the capacity for temporal projection. What remains may be a more fundamental form of presence, unencumbered by the narratives that previously structured experience.

The Hasidic teaching of *bittul*—the nullification of ego that is the goal of spiritual practice—resonates here [67]. The mystics sought deliberately what dementia accomplishes involuntarily: the loosening of the grip of the constructed self, the dissolution of the boundaries that separate individual consciousness from larger realities. This is not to romanticize dementia as spiritual achievement, but to recognize that the processes of dissolution may participate in dynamics that spiritual traditions have valued.

### **Toward Primordial Presence**

The Zohar teaches that souls return to their source through processes of ascent that involve the shedding of successive garments acquired during incarnation [68]. Memory can be understood as one such garment—a clothing of experience that the soul wears during its sojourn in the body. The loosening of this garment in dementia may represent a beginning of the soul's return journey, a movement toward the primordial presence from which it emerged.

This theological reading does not explain the suffering of dementia away. The patient remains embodied, still subject to the vulnerabilities of flesh; the family still grieves the person they knew; the caregivers still struggle with the demands of daily care. But the meaning of this suffering shifts when it is understood not as mere decay but as participation in cosmic processes of return. The terror of annihilation gives way to intimations of homecoming.

The blessing I am describing is not the blessing of pleasant experience but the blessing of sacred process. The Hebrew word for blessing (*berakhah*) shares a root with the word for knee (*berekh*)—suggesting that blessing involves bowing, yielding, submission to realities larger than the individual will [69]. The blessing of memory loss may lie precisely in its involuntary character: it accomplishes surrender that the ego would never choose, creating openings that deliberate effort could not achieve.

### **The Mercy of Unknowing**

There is mercy in not knowing what we have suffered, in being released from the compulsive rehearsal of wounds. The patient with dementia who no longer remembers the abuses of childhood, the betrayals of adulthood, the losses of old age—this patient may be experiencing a grace that memory would never permit. The past that shaped them continues to operate at deeper levels, but the narrative consciousness that kept those wounds fresh has loosened its grip.

The mystical *via negativa*—the way of unknowing that approaches the divine through negation of all concepts—finds unexpected resonance here [70]. The apophatic tradition teaches that God is known not through positive attributes but through the stripping away of all that God is not. Perhaps the forgetting of dementia participates in something analogous: a stripping away of the concepts and narratives through which we have constructed our world, creating openings for forms of knowing that transcend the conceptual.

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I do not offer this as comfort to families in the midst of dementia's devastation. The suffering is real, and spiritual reframing must not become another form of denial. But for those who can receive it, the recognition that forgetting may be blessing as well as curse—that mercy operates even in the territories of cognitive dissolution—may provide a different relationship with what cannot be changed. The acceptance that is possible when fighting becomes futile may open into peace that aggressive intervention never achieves.

### **Conclusion: Toward an Embodied Theology of Memory**

This essay has attempted to hold together what our current frameworks tend to separate: the biomedical reality of memory disorders and the spiritual dimensions of forgetting; the genuine suffering of dementia and the possibility of blessing within that suffering; the scientific understanding of neural mechanisms and the mystical recognition of consciousness as transcending its substrates. The integration I am proposing is not a synthesis that resolves these tensions but a practice of holding them simultaneously, allowing each perspective to illuminate what the others miss [71].

The clinical implications are both practical and spiritual. Practically, they call for memory care that attends to relational quality and environmental design as much as pharmacological intervention; for physician formation that includes confrontation with mortality and the limits of medical power; for institutional structures that prioritize presence over efficiency. Spiritually, they call for recognition that patients with memory loss remain persons of sacred dignity, participating in processes that transcend their individual biographies [72].

I have titled this essay 'The Blessing of Memory Loss' not to minimize the very real suffering that memory disorders bring, but to point toward dimensions of experience that our exclusively pathological framing obscures. The strange mercy in the way the mind forgets—a mercy medicine has rarely understood—becomes visible only when we expand our frameworks sufficiently to honor the full complexity of human existence. Within that expanded vision, memory loss appears not only as loss but also as release, not only as diminishment but also as opening, not only as death of self but also as intimation of return [73].

For those of us who practice medicine in the territories of memory and forgetting, this vision offers resources that biomedical training never provided. It offers a way to accompany patients and families through experiences that cannot be fixed, to be present to suffering without being destroyed by it, to recognize sacred process even in what appears to be mere decay. It offers, finally, a way to face our own cognitive futures—the forgetting that awaits us all—with something other than terror. The mercy is there, even when we cannot see it. The blessing operates, even when we cannot name it. And the strange grace of forgetting may be preparing us for forms of presence that memory itself could never achieve [74].

### **References**

1. Ungar-Sargon J. The blessing of memory loss: A philosophical and poetic essay. *Personal meditation*. 2025.
2. Ungar-Sargon J. Capitalism and health care: A critique. *Japan J Med Sci*. 2024; 5: 174-184.
3. Jack CR Jr, Knopman DS, Jagust WJ, et al. Hypothetical model of dynamic biomarkers of the Alzheimer's pathological cascade. *Lancet Neurol*. 2010; 9: 119-128.
4. Cummings J, Lee G, Nahed P, et al. Alzheimer's disease drug development pipeline: 2022. *Alzheimer's Dement (N Y)*. 2022; 8: e12295.
5. Ungar-Sargon J. Hermeneutic approaches to medicine: From objective evidence to patient as sacred text. *Adv Educ Res Rev*. 2025; 2: 40-45.
6. Ungar-Sargon J. My own spiritual crisis. *J Behav Health*. 2024; 13: 1-11.
7. Damasio AR. *Descartes' Error: Emotion, Reason, and the Human Brain*. New York: Putnam. 1994.
8. Ungar-Sargon J. Beyond the Cartesian split: The dreambody approach to chronic pain and healing. *Addict Res*. 2025; 9: 1-6.
9. Ungar-Sargon J. Worn out philosophical ideas still pervade the practice of medicine: The Cartesian split lives on. *Int J Phys Med Rehabil*. 2024; 1: 1-10.
10. Ungar-Sargon J. The unspoken terror: Mortality awareness in clinical settings for chronic and degenerative disease. *J Neurol Neurosci Res*. 2025; 6: 133-137.
11. Bartlett FC. *Remembering: A Study in Experimental and Social Psychology*. Cambridge University Press. 1932.
12. Richards BA, Frankland PW. The persistence and transience of memory. *Neuron*. 2017; 94: 1071-1084.
13. Ungar-Sargon J. The profit paradox: A critical review of pharmaceutical industry practices in modern medicine. *Int J Nurs Healthc*. 2025; 1: 1-13.
14. Ungar-Sargon J. A critical review of pharmaceutical industry fraudulent practices. *Chem Pharm Res*. 2025; 7: 1-12.
15. Walsh S, Merrick R, Milne R, et al. Aducanumab for Alzheimer's disease? *BMJ*. 2021; 374: n1682.
16. Conrad P. *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*. Baltimore: Johns Hopkins University Press. 2007.
17. Ungar-Sargon J. Reframing Alzheimer's: Toward a spiritual phenomenology of memory loss. *Arch Med Case Rep*. 2025; 6: 1-5.
18. Scholem G. *Major Trends in Jewish Mysticism*. New York: Schocken Books. 1941.
19. Ungar-Sargon J. Epistemology versus ontology in therapeutic practice: The tzimtzum model and doctor-patient relationships. *Adv Med Clin Res*. 2025; 6: 94-101.
20. Ungar-Sargon J. Divine error and human rectification: Tzimtzum as theological rupture and therapeutic possibility. *Adv Educ Res Rev*. 2025; 2: 76-86.

21. Ungar-Sargon J. The dialectical divine: Tzimtzum and the parabolic theology of human suffering. *J Relig Theol.* 2025; 7: 49-58.
22. Green A. *Ehyeh: A Kabbalah for Tomorrow.* Woodstock, VT: Jewish Lights Publishing. 2003.
23. Ungar-Sargon J. Divine presence and concealment in the therapeutic space. *EC Neurol.* 2025; 17: 1-13.
24. Ungar-Sargon J. Revelation in concealment: Theological reflections on the therapeutic encounter III. *Am J Med Clin Res Rev.* 2025; 4: 1-12.
25. Locke J. *An Essay Concerning Human Understanding.* Book II, Chapter XXVII. Oxford: Clarendon Press. 1975.
26. Wolfson ER. *Through a Speculum That Shines: Vision and Imagination in Medieval Jewish Mysticism.* Princeton: Princeton University Press. 1994.
27. Ungar-Sargon J. Shekhinah consciousness: Divine feminine as theological and political paradigm for human suffering. *EC Neurol.* 2025; 17: 1-15.
28. Ginzberg L. *Legends of the Jews.* Vol. 1. Philadelphia: Jewish Publication Society. 1909.
29. Ungar-Sargon J. The hidden light in the therapeutic space: From ancient mystical wisdom to contemporary therapeutic transformation. *Am J Med Clin Res Rev.* 2025; 4: 1-17.
30. Sabat SR. *The Experience of Alzheimer's Disease: Life Through a Tangled Veil.* Oxford: Blackwell. 2001.
31. Ungar-Sargon J. Seeing through divine eyes: Beyond the veil of sacred text—The Me'or Einayim's vision of transcendent reading. *Adv Med Clin Res.* 2025; 6: 157-166.
32. Ungar-Sargon J. Applying hermeneutics to the therapeutic interaction: The act of interpreting the patient history as a sacred text. *Int J Psychiatry Res.* 2025; 8: 1-6.
33. Ungar-Sargon J. The patient as parable: Highlighting the interpretive framework. *Int Med J.* 2025; 25: 41-50.
34. Pirkei Avot 5:22. Mishnah.
35. Ungar-Sargon J. The art of sacred listening: Divine presence and clinical empathy in contemporary medical history taking. *Rev Theol.* 2025; 25: 85-97.
36. Ungar-Sargon J. Presence within and beyond words: Sacred listening as experiential encounter. *Am J Med Clin Sci.* 2025; 10: 1-7.
37. Nouwen HJM. *The Wounded Healer: Ministry in Contemporary Society.* New York: Doubleday. 1972.
38. Ungar-Sargon J. My own spiritual crisis. *J Behav Health.* 2024; 13: 1-11.
39. Ungar-Sargon J. My own inner crisis II. *J Behav Health.* 2025; 14: 1-8.
40. Ungar-Sargon J. Coming to believe in a post-belief world: Mysticism, recovery, and clinical applications of Step 2. *Addict Res.* 2025; 9: 1-6.
41. Ungar-Sargon J. The unspoken terror: Mortality awareness in clinical settings for chronic and degenerative disease. *J Neurol Neurosci Res.* 2025; 6: 133-137.
42. Ungar-Sargon J. Sacred and profane space in the therapeutic encounter: Moving beyond rigid distinctions. *Am J Neurol Res.* 2025; 4: 1-9.
43. Ungar-Sargon J. The spiritual space between nurse and patient. *Glob J Crit Care Emerg Med.* 2025.
44. Ungar-Sargon J. Beyond the iron cage: Institutional coercion and the imperative for transformative healing spaces. *J Behav Health.* 2025; 14: 1-9.
45. Matt DC. *Zohar: The Book of Enlightenment.* New York: Paulist Press. 1983.
46. Ungar-Sargon J. A framework for transformative healthcare practice. *Am J Med Clin Res Rev.* 2025; 4: 1-40.
47. Schacter DL. *The Seven Sins of Memory: How the Mind Forgets and Remembers.* Boston: Houghton Mifflin. 2001.
48. Loftus EF. The malleability of human memory. *Am Sci.* 1979; 67: 312-320.
49. Nader K, Schafe GE, Le Doux JE. Fear memories require protein synthesis in the amygdala for reconsolidation after retrieval. *Nature.* 2000; 406: 722-726.
50. Davis RL, Zhong Y. The biology of forgetting—a perspective. *Neuron.* 2017; 95: 490-503.
51. Ungar-Sargon J. Bridging neural circuits and sacred spaces: Integrating neurobiological mechanisms with intangible experience. *Med Clin Res Open Access.* 2025; 6: 1-11.
52. Ungar-Sargon J. Beyond the synapse: Ethical horizons in neurodegenerative research. *Med Case Rep Rev.* 2025; 6: 1-6.
53. Diekelmann S, Born J. The memory function of sleep. *Nat Rev Neurosci.* 2010; 11: 114-126.
54. Ungar-Sargon J. Beyond the synapse: Ethical horizons in neurodegenerative research. *Med Case Rep Rev.* 2025; 6: 1-6.
55. Chalmers DJ. *The Conscious Mind: In Search of a Fundamental Theory.* New York: Oxford University Press. 1996.
56. Ungar-Sargon J. Beyond theodicy: The physician's existential crisis. *Adv Med Clin Res.* 2025; 6: 102-105.
57. Ungar-Sargon J. Navigating the depths: A framework for caregiver's grief work. *J Behav Health.* 2025; 14: 1-9.
58. Ungar-Sargon J. The sacred space of surrender: Transforming physician-patient vulnerability into healing power. *J Behav Health.* 2025; 14: 14-26.
59. Ungar-Sargon J. When the healer mourns: Physician grief after a patient's death. *Trends Gen Med.* 2025; 3: 1-10.
60. Ungar-Sargon J. Embodied theology for end-of-life care: A being-with-nonbeing approach to dying patients. *KOS J Public Health Integr Med.* 2025; 1: 1-23.
61. Ungar-Sargon J. Healthcare reforms within and without. *Am J Med Clin Sci.* 2024; 9.
62. Ungar-Sargon J. Revisioning healthcare in a different key. *Arch Case Rep Open.* 2024; 1: 1-7.
63. Ungar-Sargon J. A healing space for caregiver and patient:

- 
- A novel therapeutic clinic model integrating holistic healing principles. *Med Clin Case Rep.* 2025; 5: 1-11.
64. Ungar-Sargon J. A healing space for caregiver and patient: A novel therapeutic clinic model. *Med Clin Case Rep.* 2025; 5: 1-11.
65. Ungar-Sargon J. The sacred shadow: Kabbalistic heresy and the antinomian roots of medical dissent. *J Tradit Med Appl.* 2025; 4: 1-10.
66. Freud S. *Beyond the Pleasure Principle.* Standard Edition Vol. 18. London: Hogarth Press. 1920.
67. Tanya (Likutei Amarim). Part I, Chapter 35. Brooklyn: Kehot Publication Society. 1981.
68. Matt DC. *The Zohar: Pritzker Edition.* Stanford: Stanford University Press. 2004.
69. Hirsch SR. *The Etymology of Hebrew Words.* Jerusalem: Feldheim Publishers. 1988.
70. Turner D. *The Darkness of God: Negativity in Christian Mysticism.* Cambridge: Cambridge University Press. 1995.
71. Ungar-Sargon J. Beyond reductionism or wishful thinking? Tensions between evidence-based practice and spiritual frameworks in contemporary healthcare. *Trends Intern Med.* 2025; 5: 1-10.
72. Ungar-Sargon J. Healing as justice: Clinical advocacy in therapeutic practice. *J Med Clin Res Rev.* 2025; 9: 1-10.
73. Ungar-Sargon J. Revelation in concealment: Toward an embodied post-Holocaust spirituality. *J Relig Theol.* 2025; 7: 1-23.
74. Ungar-Sargon J. The divine paradox in clinical practice: Presence, absence, and the therapeutic encounter. *Trends Gen Med.* 2025; 3: 1-9.