

How Memory Lives in the Patient Encounter

Remembering, feeling, prediction, and the chaplain's own response

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Abstract

Memory is commonly spoken of as though it were a single faculty: either we remember something or we do not. Clinically, this is profoundly misleading. Human memory is a collection of interacting systems. Some forms of memory can be consciously recalled and narrated; others operate through feeling, perception, bodily readiness, habit, expectation, and relationship without becoming an autobiographical story. A patient may be unable to describe an earlier event and yet respond powerfully to a tone of voice, a uniform, a smell, a facial expression, or the prospect of being left alone. Conversely, a patient may recount an event in detail while remaining largely cut off from the feeling state associated with it. Neither presentation is unusual.

For chaplains, memory is not an abstract topic. It is present in nearly every encounter: in what patients tell us, in what they cannot tell us, in what their bodies seem to anticipate, in the religious meanings they have learned, and in the relational roles they invite us to occupy. It is also present in us. Our own implicit expectations and remembered relationships shape what we notice, how we feel, and what we are tempted to do. This paper offers a clinically usable account of explicit and implicit memory, trauma, predictive processing, and reconsolidation, and connects them to listening, observation, spiritual care, and countertransference. Its central claim is simple: the chaplain is not merely listening to a person's memories. In every clinical encounter, memory is meeting memory—and the possibility of a new experience enters the room.

Keywords: *memory, explicit memory, implicit memory, trauma, predictive processing, reconsolidation, countertransference, clinical chaplaincy*

The patient who “does not remember”

A patient says that she remembers almost nothing about the automobile collision. She cannot put the event into a sequence. Yet the monitor alarm sounds and her body stiffens before she can identify what

frightened her. Another patient can tell us precisely when his diagnosis was made, what the physician said, and what treatment was recommended, but he repeats, “I still cannot believe this is happening to me.” A third, living with advanced dementia, does not remember the chaplain’s name or the previous visit, but settles when the same hymn is sung slowly. A nurse who has participated in a difficult code begins to tremble when she hears the suction equipment in another room. A devout patient says, with complete sincerity, “I know God is loving,” while every aspect of his posture and speech seems organized around an expectation of punishment.

All of these persons are remembering. They are simply not remembering in the same way.

The ordinary way we speak about memory privileges episodic recall: the capacity to bring back a scene, locate it in time and place, and say what happened. That capacity matters enormously. It contributes to identity, testimony, grief, meaning, and the continuity of a life. But episodic recollection is only one form of memory. Much of what experience leaves behind is unavailable as a scene and cannot be summoned by trying harder. It persists instead as knowledge, expectation, attention, bodily preparation, emotional response, relational habit, or a change in what the person notices and how the person acts.

A first clinical distinction

Not being able to narrate an episode does not mean that nothing was learned from it. At the same time, a powerful feeling or bodily response is not proof that a particular historical event occurred. The experience is real as present experience; its precise historical explanation may remain uncertain.

Memory is plural

The modern study of memory moved decisively away from the idea of a single storage system. Research with persons who had profound amnesia showed that conscious recollection could be severely impaired while learning, skill, conditioning, and other forms of retention remained. We now speak more accurately of memory systems: partially distinct forms of learning and retention supported by overlapping but different neural networks.

The broadest clinically useful distinction is between explicit—or declarative—memory and implicit—or non-declarative—memory. Explicit memory includes facts and personally experienced events that can, under suitable conditions, become available to conscious recollection. Implicit memory is expressed in performance, perception, feeling, and response without requiring conscious recall. The distinction is functional rather than absolute. The systems interact continuously, and a single experience may leave traces in several of them.

The memory maps used throughout this paper are teaching diagrams. They simplify a networked brain and should not be read as though each kind of memory were stored in one small anatomical box. Their value is that they prevent us from reducing all remembering to the production of a coherent story.

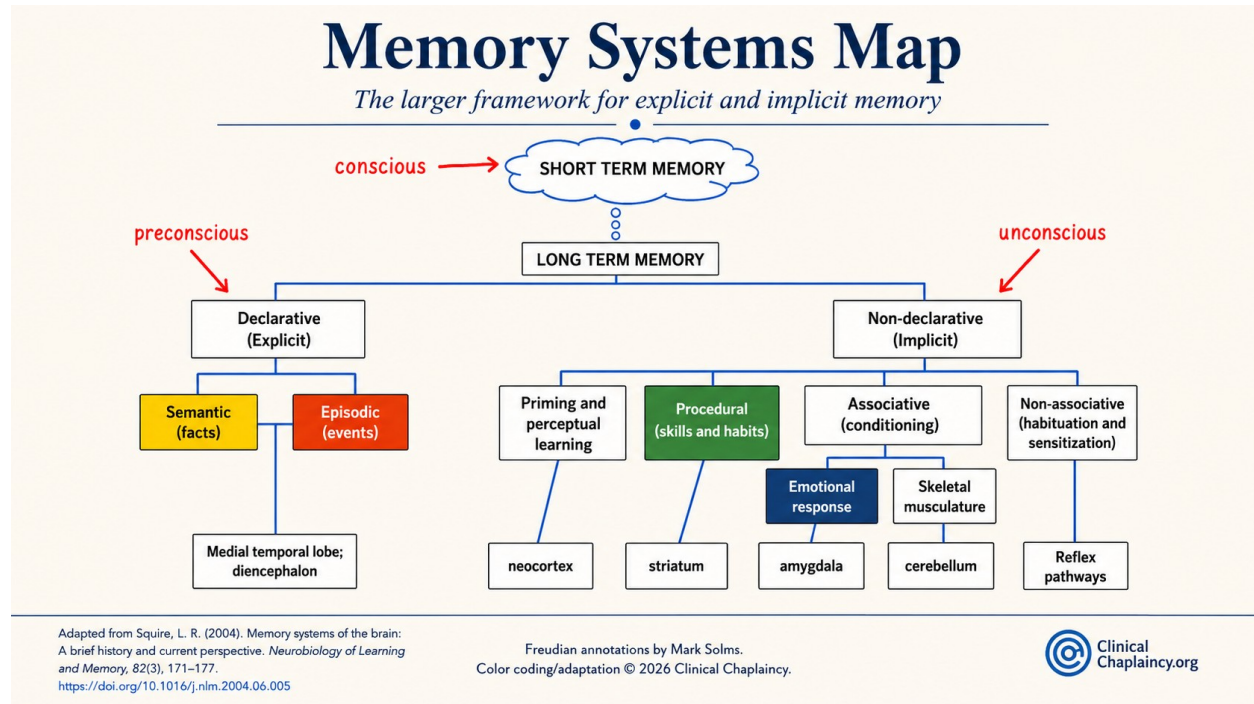


Figure 1. Memory systems map: a larger framework for explicit and implicit memory.

Explicit memory: what can be known and told

Explicit memory has two major forms. Semantic memory is memory for facts, concepts, meanings, categories, and general knowledge. Episodic memory is autobiographical memory for personally experienced events situated—however imperfectly—in time and place.

The distinction becomes immediately useful in spiritual care. A patient may possess a well-developed semantic theology: God is merciful; suffering is not necessarily punishment; the community will support me; death is part of life. Yet the patient's episodic memories may contain humiliating encounters with clergy, unanswered pleas for help, or a parent's death in which religious language was used harshly. The person may know one thing and expect another. Correcting the doctrine does not necessarily alter the expectation.

Semantic memory is not emotionally neutral. Meanings become organized into schemas—learned structures through which later experience is interpreted. "I must not burden anyone." "Strong people do not cry." "A good mother keeps the family together." "Illness means God has withdrawn favor." Such propositions may be stated openly, but often they become visible only through their effects. They tell the person what kind of situation this is, who the person is within it, and what responses are permitted.

Episodic memory gives us the remembered scene: the physician standing near the door, the telephone call at 2:00 a.m., the last words of a spouse, the moment the body failed, the church service in which one was welcomed or shamed. Episodic recollection is constructive. It is assembled in the present from available traces, current meanings, and the demands of the moment. This does not make memory merely fictional. It means that remembering is not the replay of a fixed recording. Details may be accurate, mistaken, absent, rearranged, or newly emphasized while the person remains entirely sincere.

Implicit memory: what experience teaches without becoming a story

Implicit memory contains several distinguishable forms. Priming and perceptual learning alter what is noticed or recognized after prior exposure. Procedural memory supports skills, habits, and embodied know-how. Associative learning links cues with expected emotional or motor responses. Non-associative learning includes habituation, in which response decreases to repeated harmless stimulation, and sensitization, in which response increases after strong or repeated stimulation.

These are not minor forms of memory. They do much of the practical work of living. We do not consciously reconstruct every step required to stand, speak, type, drive, recite a familiar saying or prayer, read a face, or decide whether an approaching person is safe. Prior learning prepares perception and action before reflective thought catches up.

Religious and spiritual life is saturated with implicit memory. The body may know how to kneel, cross itself, handle a rosary, begin a familiar blessing, or enter the cadence of a Psalm before the person can explain the action. A hymn can summon a feeling of belonging or dread. The word “Father” may signify God semantically while functioning as an associative cue for a particular human relationship. A clerical collar, a yarmulke, the sight of a Bible, or the phrase “Let us pray” may prime comfort in one person and danger in another.

Memory Systems at a Glance

Categories, descriptions, and examples

Category	What it is	Simple example	Clinical / trauma example
EXPLICIT MEMORY			
 Semantic memory	Memory for meanings, facts, concepts, and general knowledge — knowing that.	You know that a bicycle has two wheels.	A person may know the facts of what happened without a coherent personal recollection of the event.
 Episodic memory	Autobiographical memory for personally experienced events in time and place.	You remember falling off your bike on Maple Street when you were eight.	Trauma may leave flashes of sound, image, or place without a coherent sequence.
IMPLICIT MEMORY			
 Priming & perceptual learning	Prior exposure changes later perception or recognition without conscious recollection.	After seeing the word 'chapel,' you recognize related words more quickly.	A smell, tone, or doorway may feel threatening before the person knows why.
 Procedural memory	Memory for skills, habits, and embodied know-how — knowing how.	Riding a bike, typing a password, or driving a familiar route.	The body may automatically tense, brace, or go guarded without deliberate thought.
 Associative memory — emotional response	Learning that a cue has emotional value and predicts danger, comfort, loss, or safety.	After being bitten, the sight of a large dog evokes fear.	A monitor alarm or the smell of alcohol may trigger panic or dread before the person can explain it.
 Associative memory — skeletal musculature	Learned motor responses to predictive cues.	A tone that predicts an air puff leads the body to blink.	The body may duck, freeze, or recoil when a hand rises or a door slams.
 Non-associative memory — habituation	Response decreases when a repeated stimulus proves harmless.	A ticking clock fades into the background.	A patient or staff member may stop reacting to routine hallway noise or monitor beeps.
 Non-associative memory — sensitization	Response increases after strong or repeated stimulation.	After a frightening bang, even small sounds make you jump.	Ordinary touch, noise, or conflict may evoke an amplified response after trauma.

Conceptual summary based largely on Squire / Tulving; affective bridge from Panksepp / Solms.

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Figure 2. Memory systems at a glance: categories, descriptions, and clinical examples.

A chaplaincy translation of the memory systems

Memory system	How it may appear	What we may notice clinically
Semantic	Facts, beliefs, concepts, religious meanings, identity statements.	"I know..."; doctrinal formulations; global meanings such as punishment, abandonment, duty, hope, or shame.
Episodic	Scenes and events situated in a personal past.	Stories, flashes, gaps, repeated scenes, time confusion, sensory fragments, and changes in narrative sequence.
Priming / perceptual	Prior exposure changes what is noticed or recognized.	A face, smell, doorway, tone, title, or religious symbol feels familiar, salient, or threatening before the person knows why.
Procedural	Skills, habits, embodied and relational know-how.	Automatic prayer forms, bracing, appealing, withdrawing, caretaking, joking, controlling, or becoming "the good patient."
Associative — emotional	A cue predicts danger, comfort, loss, shame, or safety.	Sudden fear, grief, calm, anger, or longing that is disproportionate to the visible moment or arrives without narrative explanation.
Associative — motor	A cue elicits learned bodily readiness.	Flinching, freezing, turning away, gripping the bedrail, lowering the voice, guarding the body, or moving toward contact.
Habituation / sensitization	Response decreases to harmless repetition or increases after strong stimulation.	The patient stops hearing routine alarms—or reacts intensely to ordinary touch, noise, interruption, conflict, or uncertainty.

Conscious, preconscious, and unconscious

The slides place a Freudian vocabulary alongside the cognitive-neuroscientific map: conscious, preconscious, and unconscious. This is useful if we treat the terms carefully. They are not exact anatomical equivalents. “Conscious” refers to what is presently experienced. “Preconscious” refers to material not presently in awareness but potentially retrievable. “Unconscious” refers, in this context, to processes that influence experience and action without becoming accessible in their operating form to introspection.

Much implicit memory is unconscious in precisely this functional sense. We experience the result without observing the process that produced it. The patient feels uneasy, trusts the nurse, dislikes the room, expects criticism, or knows that the chaplain is “not for me.” The judgment may arrive fully formed. What is hidden is not necessarily a repressed episode waiting intact in a vault. What is hidden may be the accumulated learning by which the nervous system came to predict what this kind of person, place, touch, tone, or relationship means.

This distinction protects us from two opposite mistakes. One mistake is to dismiss what cannot be narrated: “There is no memory, so there is nothing there.” The other is to assume that every powerful feeling must correspond to a recoverable event: “Your body remembers, therefore this specific thing must have happened.” Both exceed what we know.

What a memory trace is—and is not

A memory trace is not a miniature photograph hidden somewhere in the brain. It is a lasting change in the organism’s disposition to perceive, feel, predict, and act. Some traces can contribute to conscious recollection. Others are known only through what they do.

How memory enters the patient encounter

A clinical encounter contains more memory than either participant can report. The patient brings remembered events, learned meanings, sensory associations, bodily habits, expectations of authority, and prior experiences of care. The chaplain brings the same. The room itself has a memory-bearing structure: uniforms, alarms, doors, schedules, touch, questions, rituals, and asymmetries of power. The encounter is therefore never only about the present, even when no one speaks of the past.

The narrated story

We naturally listen for content: what happened, who was present, what was said, what the illness means. We must also listen to the form of the telling. Is the story sequential or circular? Does the person move abruptly from the present to an earlier time? Are there vivid islands surrounded by uncertainty? Are the facts fluent while feeling disappears, or does emotion surge where words fail? Does the patient repeatedly

correct minor details as though accuracy might provide safety? Does the story recruit us to confirm innocence, assign blame, restore order, or witness what no one has believed?

None of these observations licenses an immediate interpretation. They tell us where attention may be needed. Narrative coherence is influenced by fatigue, medication, pain, culture, education, language, acute stress, delirium, dementia, and the ordinary reconstructive nature of memory. A gap is a gap before it is evidence of trauma. When we suspect an acute cognitive change, we bring it to the clinical team rather than psychologizing it.

The feeling that arrives before the explanation

At other times the most important memory is represented as affect. A patient becomes frightened when the door closes, ashamed when assistance is offered, angry when choices are limited, or unexpectedly calm when a particular prayer is spoken. The person may say, “I know this makes no sense.” It may make excellent implicit sense. The present cue has activated an earlier pattern of prediction and response.

The clinical question is not first, “What hidden event caused this?” It is, “What changed in the room just before the feeling changed?” We attend to sequence: the physician left; the chaplain moved closer; the patient heard the word hospice; a family member entered; the blanket was pulled back; the visitor used a title associated with authority. The cue may be interpersonal, sensory, bodily, symbolic, or internal.

The body that prepares

Implicit memory often appears as preparation. The body leans away, becomes still, scans the doorway, lowers the voice, tightens the jaw, smiles compliantly, reaches for the chaplain, or begins to care for the caregiver. These are not transparent signs with fixed meanings. A lowered gaze can mean reverence, shame, fatigue, culture, pain, or avoidance. What matters is the pattern and its context.

We are especially attentive to relational procedures: the automatic ways a person has learned to remain connected or protected. Some patients become pleasing; some become controlling; some disappear into politeness; some test whether we will leave; some provoke the rejection they expect; some offer us a role as rescuer, judge, confessor, parent, child, expert, or adversary. The patient may not be remembering the chaplain. The patient may be remembering through the chaplain.

Religious memory in conflict with itself

Spiritual care frequently reveals a conflict among memory systems. A patient can state a theology of grace while responding emotionally as though God were punitive. Another can remember a congregation’s kindness while the presence of clergy evokes shame. A third can no longer explain the words of a liturgy but participates in its rhythm. A fourth rejects religious language semantically but experiences a familiar blessing as deeply regulating.

Our task is not to decide which level is the “real” belief. All are real expressions of learned organization. The discrepancy itself is clinically meaningful. “Part of you knows you are loved, and another part seems to expect judgment” may open more space than repeating the doctrine with greater force. Chaplaincy becomes clinically precise when it can hold knowledge, feeling, body, relationship, and meaning together without collapsing one into another.

Trauma as a window into memory

Trauma makes the plurality of memory easier to see because the systems may become strikingly dissociated. A person may have clear factual knowledge of what happened but little felt connection to it. Another may experience intrusive images, sounds, or bodily states without a coherent autobiographical sequence. Another may remember the event well and nevertheless react to present cues as though the danger were recurring. Trauma is not the only source of such patterns, and not every traumatic memory is fragmented. But trauma demonstrates that what can be said and what can be felt do not always travel together.

The four-part teaching model—semantic, episodic, emotional, and procedural memory—shows why a person can “know” the present is safe and still feel endangered. Semantic memory carries the proposition. Episodic memory may carry scenes or fragments. Emotional associative memory supplies the feeling state. Procedural memory supplies the habitual response. These systems can be updated at different rates.

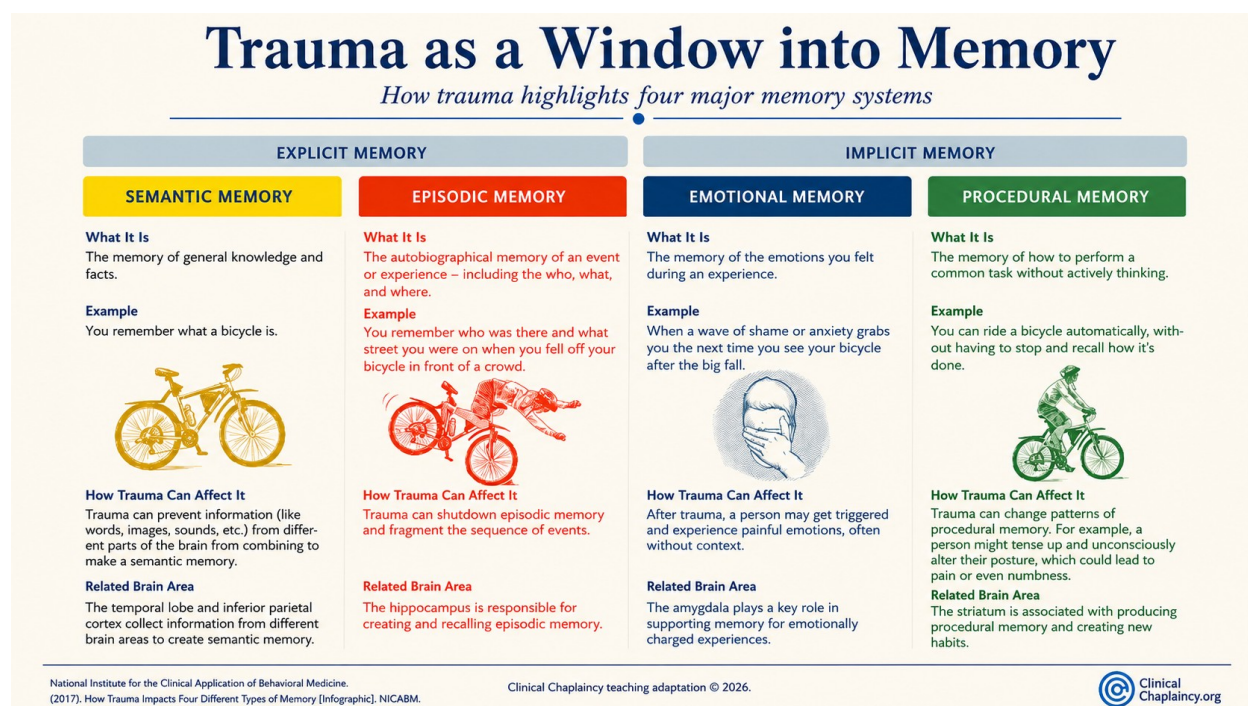


Figure 3. Trauma as a window into four major memory systems.

What chaplains must not do with traumatic memory

The existence of implicit memory does not authorize a search for buried episodes. Memory is suggestible, and autobiographical recollection is constructed rather than replayed. Leading questions, confident interpretations, guided imagery directed toward presumed events, and repeated invitations to “go back” can alter belief and recollection. Chaplains should not attempt recovered-memory work, and we should be cautious whenever a patient, family member, or clinician treats a present feeling as forensic proof of an unremembered event.

This caution does not require skepticism toward suffering. We can trust the patient’s present experience without claiming more historical certainty than the evidence allows. We may say: “Something about this feels frightening.” “Your body seems to become guarded when that subject comes up.” “You do not have to force yourself to remember.” “We can stay with what you are experiencing now.” Such responses validate experience, preserve agency, and avoid planting an explanation.

We must also avoid making trauma the master explanation for every difficulty. Pain, hypoxia, medication, sleep loss, delirium, dementia, depression, anxiety, sensory impairment, culture, and immediate threat all shape attention and memory. Clinical humility requires us to observe, describe, collaborate, and refer rather than diagnose beyond our competence.

A sentence worth keeping

What is felt is real as felt. It may reveal a learned expectation. It does not, by itself, establish the exact event by which that expectation was learned.

Memory is prediction

Memory is often described as a faculty for preserving the past. Biologically, its more urgent purpose is to guide the future. The nervous system uses prior learning to predict what is happening, what will happen next, and what action will best protect or sustain the organism. Perception is therefore not a passive reception of the world. Incoming sensation is interpreted through expectations built from prior experience.

In predictive-processing language, these expectations are priors. Most operate outside awareness. When incoming information fits the prediction, experience proceeds with little disturbance. When reality differs sufficiently from what was expected, prediction error—or Bayesian surprise—appears. Attention increases. Feeling may intensify. The organism can update its model, change the situation, or act to make the world conform more closely to expectation.

This gives us a clinically powerful way to understand repetition. A patient who has repeatedly been abandoned may carry a strong prior that helpers leave. The prior shapes what is noticed: the chaplain's glance toward the clock, a delay in returning, the sound of a pager. Ambiguous cues are organized as evidence. The patient may withdraw before being left, cling in order to prevent departure, or dismiss the chaplain as useless. Each response can help produce the very outcome that confirms the prediction.

The same is true of spiritual expectations. A patient who learned that religious authority humiliates may experience a chaplain's confidence as domination. A patient who learned that care is available only after self-denial may minimize need until crisis. A patient who expects God to punish may notice every setback as confirmation and discount moments of mercy as irrelevant exceptions.

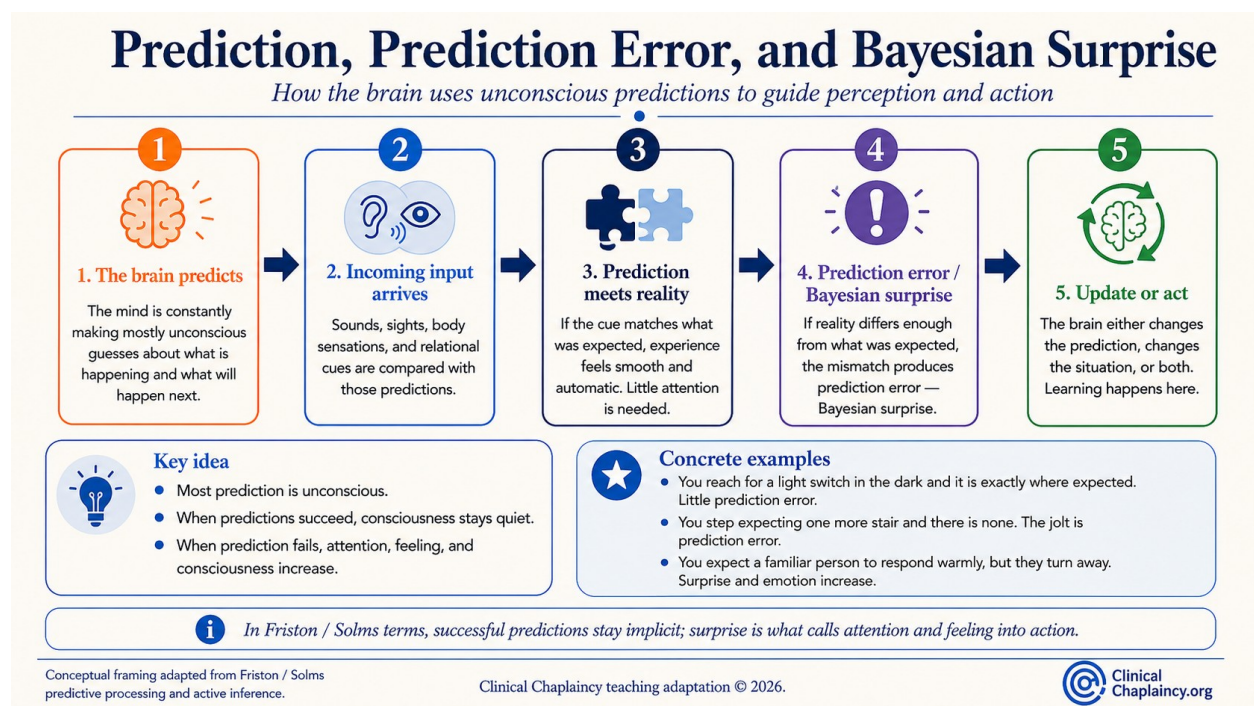


Figure 4. Prediction, prediction error, and Bayesian surprise.

The chaplain is part of the prediction

When we enter the room, we do not arrive as blank human beings. We are perceived through categories already learned: clergy, hospital employee, stranger, authority, comforter, intruder, witness, moral judge, rescuer, representative of God, or person who comes when death is near. The patient's response to us may be formed before we have said enough to deserve it.

We should not take this personally, but neither should we treat it as unreal. It is the patient's best current prediction, built from a life of experience. Our role gives that prediction a place to appear. The clinical opportunity is to discover what kind of encounter the patient expects and whether we can offer something sufficiently different to be noticed without overwhelming the person.

Prediction error is not automatically therapeutic. Surprise can terrify. A patient who expects intrusion may experience sudden warmth as manipulation. A person accustomed to chaos may distrust calm. The new experience must be tolerable, emotionally meaningful, and repeated enough to be taken in. Safety without engagement changes little; activation without safety may simply confirm danger.

Reconsolidation: how old learning can be updated

Memory is not permanently fixed after initial storage. When some consolidated memories are reactivated, they can enter a temporary state of instability before being stored again. This process is called reconsolidation. Under appropriate conditions, new information can become incorporated into the reactivated memory network. The old learning is not simply deleted. Rather, what the cue predicts, means, and evokes may be revised.

Richard Lane and colleagues have proposed a clinically useful model in which enduring change involves three interrelated processes: activation of old autobiographical and emotional memory; a new emotional experience that differs from what the old model predicted; and repeated practice that integrates the new experience into meaning and behavior. The model links episodic memory, semantic structure, and emotional response. Procedural habits often change more slowly because they are reinforced across many contexts.

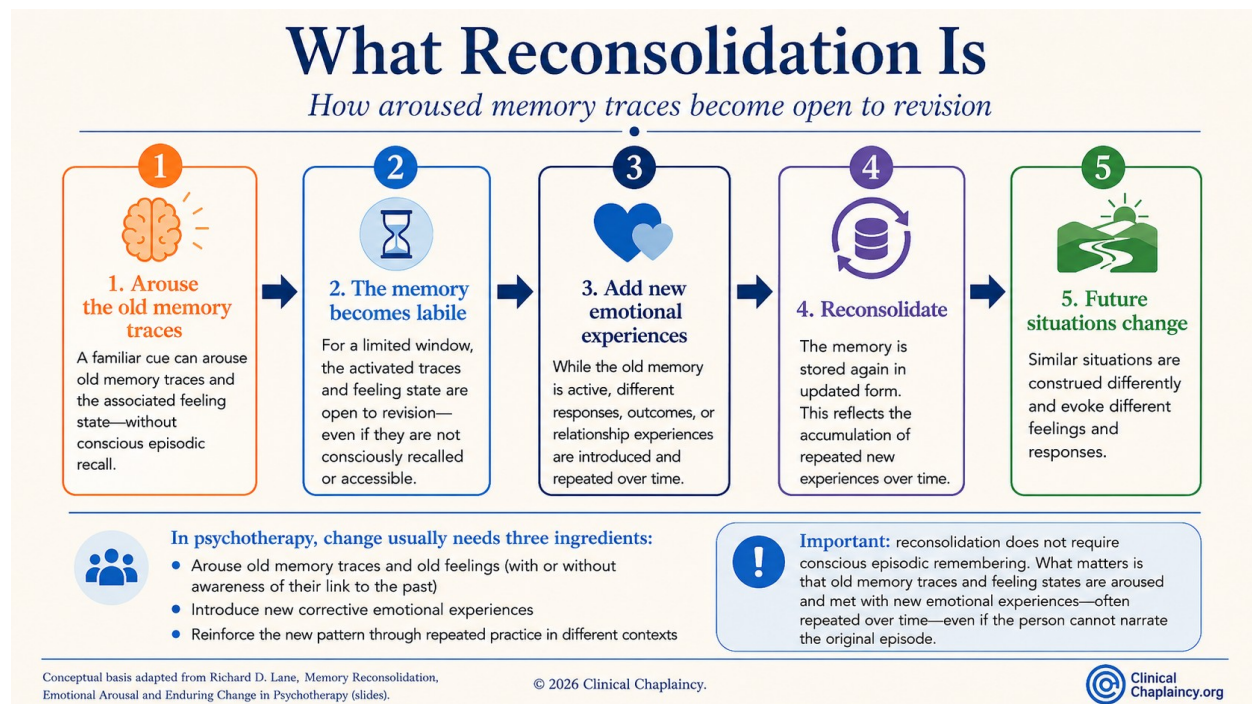


Figure 5. What reconsolidation is: activated memory becomes open to revision.

Reconsolidation is sometimes presented too simply, as though one dramatic mismatch erases a trauma. The evidence does not justify such certainty. Not every retrieval makes a memory labile; boundary conditions matter; different memory systems may respond differently; and clinical change cannot be reduced to a single laboratory mechanism. Reconsolidation is best understood here as a disciplined model of how new experience can revise old expectation—not as a promise that the past can be overwritten on command.

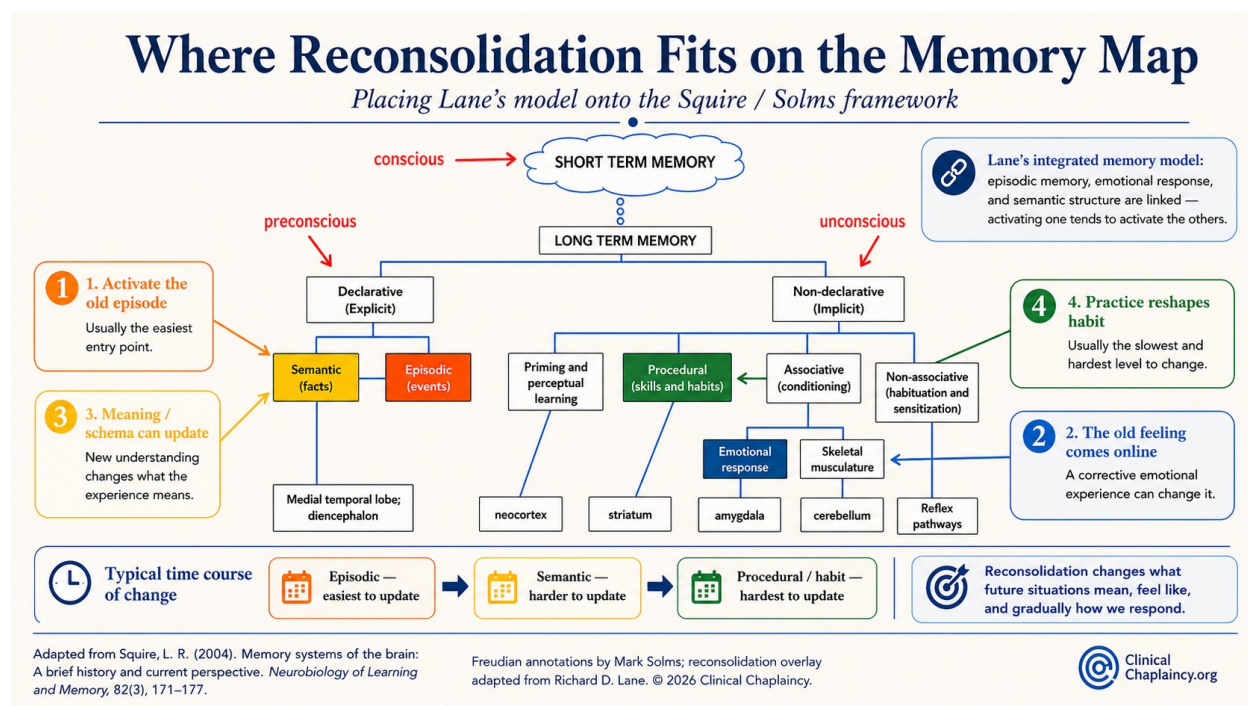


Figure 6. Where reconsolidation fits on the memory map.

What a chaplain may contribute

Chaplains are not ordinarily conducting trauma psychotherapy. We should not manufacture emotional arousal, press for disclosure, or claim to reconsolidate memories. Yet a well-conducted chaplaincy encounter can provide precisely the kind of bounded relational experience through which old predictions are tested and, sometimes, revised.

A patient expects religious judgment and receives curiosity without condemnation. A patient expects abandonment and finds that the chaplain returns when promised. A patient expects emotion to drive others away and discovers that grief can be expressed without the relationship collapsing. A patient expects silence to be empty and experiences it as accompanied. A patient who has always had to care for others is allowed, without humiliation, to receive care.

No single encounter guarantees change. But the new experience matters because it is not merely explained; it is lived. Meaning can then be named: “You expected me to be disappointed, and I am still

here.” “You were able to say no, and our relationship remained intact.” Repetition across chaplain, family, nursing, medicine, therapy, and community gives the revised prediction a better chance to become available in future situations.

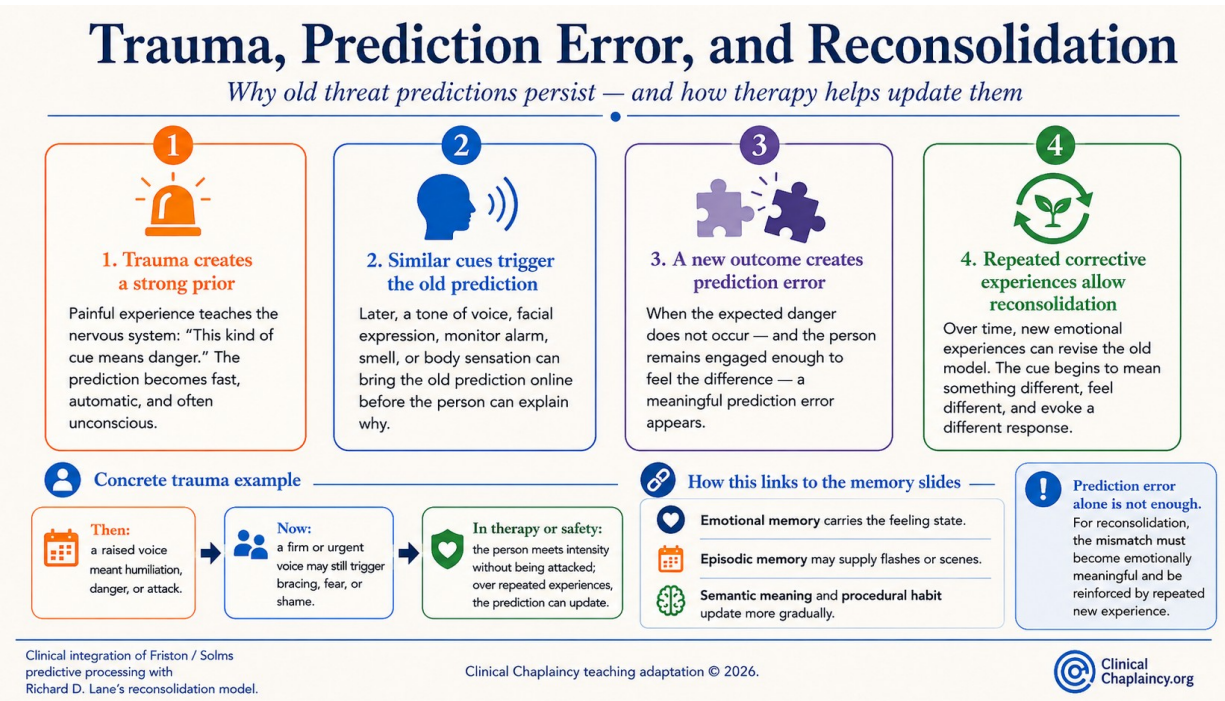


Figure 7. Trauma, prediction error, and reconsolidation: how repeated corrective experience can revise threat predictions.

The chaplain's own memory: countertransference as prediction

The patient is not the only person whose memory systems are active. We bring our own semantic beliefs, episodic histories, emotional associations, relational procedures, and sensitizations into the room. Much of this arrives as countertransference: the totality of our conscious and unconscious response to the patient, the family, the team, the institution, and the role we have been given.

Countertransference is often discussed as feeling, but it is equally a form of prediction. Before we understand the patient, we are already anticipating what kind of encounter this will be. The patient resembles someone. The family conflict has a familiar shape. The diagnosis evokes a remembered loss. The patient's anger predicts attack; helplessness predicts rescue; religiosity predicts alliance or danger. We may feel urgency, tenderness, irritation, dread, boredom, protectiveness, attraction, moral certainty, or an impulse to leave. Our bodies may tighten, soften, become sleepy, lean forward, or begin preparing an answer before the patient has finished.

These responses can contain useful information, but they are not self-interpreting. Countertransference can be data; it is not a verdict. The feeling may arise from the patient's way of organizing relationship, from

the institutional field, from our own history, or from all three. The clinical discipline is to notice the response without immediately obeying it.

Memory meeting memory

The chaplain may be invited into a familiar role while simultaneously assigning the patient a familiar role. Clinical reflection asks two questions at once: “What may the patient be expecting from me?” and “What am I expecting from this patient?”

How countertransference can pull us out of role

Implicit memory often shows itself as action before it becomes thought. We pray too quickly because silence once meant danger. We reassure because another person’s despair feels unbearable. We become doctrinal because uncertainty threatens us. We overstay because leaving evokes guilt, or leave early because dependency evokes entrapment. We identify with the family and subtly oppose the patient, or identify with the patient and treat staff as persecutors. We interpret familiarity as intimacy and cross a boundary, or interpret intensity as threat and retreat behind professional distance.

TRAB-S helps us examine these movements. Has memory altered our Task? Has it inflated or diminished our Role? Are we using Authority that has not been given, or failing to use authority that belongs to the role? Has the Boundary become too porous or too rigid? Have we lost contact with the patient as a subject—with Soul, consciousness, and felt experience—because the person has become a figure in our own remembered drama?

Supervision is therefore not an accessory to clinical chaplaincy. It is one of the places where implicit response can become thinkable. We reconstruct the sequence: what happened immediately before the shift in feeling; what role we were invited to occupy; what we wanted to do; what we actually did; what belonged to the task; and what may have belonged to us. The aim is not purification from countertransference. That is impossible. The aim is to use our response without being used by it.

Listening and observing with memory in mind

A memory-informed chaplain does not conduct an interrogation. We widen the field of attention. We listen to what is remembered, what is known, what is felt, what is enacted, and what is predicted. We also remain alert to cognitive and medical conditions that require collaboration with the team.

1. Listen for the difference between fact, scene, feeling, and habit

A patient may know the facts but lack a scene; have a scene without words for the feeling; feel the danger without recalling an episode; or repeat a procedure without understanding why. We do not force these into false unity. We may gently differentiate them: “You know what the physician said, but it still does not

feel real.” “You cannot picture what happened, but the alarm brings fear very close.” “You believe God forgives, and shame is still present.”

2. Track the immediate cue

When affect or posture changes, we become curious about the preceding moment. What word, movement, sound, person, image, bodily sensation, or shift in distance came just before? The question keeps us grounded in observable sequence and may help the patient recognize a trigger without requiring a historical explanation.

3. Ask permission and preserve reversibility

Implicit threat is often intensified by loss of control. We announce ourselves, ask where to sit, explain what we are doing, and make it possible to stop. Consent is not merely ethical procedure. It is a new relational experience for persons whose prior learning says that authority acts upon them without consultation.

4. Do not confuse activation with depth

A highly emotional encounter is not necessarily a more therapeutic one. The patient may be flooded rather than engaged. We watch the person’s capacity to remain present, orient to the room, choose, speak, pause, and recover. When activation exceeds capacity, we reduce intensity, restore orientation, involve the team, or refer. Clinical chaplaincy does not prove its seriousness by taking people farther than they can safely go.

5. Let meaning emerge without imposing an explanation

Semantic memory can change when a person finds a new way to understand what has happened. Chaplains are trained to work with meaning, but our advantage becomes a liability when we provide meaning prematurely. We offer language tentatively: “I wonder whether...” “It seems...” “Perhaps...” We distinguish the patient’s theology from our own and allow contradiction to remain long enough to become thinkable.

6. Use ritual as embodied communication

Ritual can engage several memory systems at once. Familiar words activate semantic and episodic associations; rhythm and gesture recruit procedural memory; symbol and relationship carry emotional meaning. This is one reason ritual can remain potent when ordinary conversation is limited. It is also why ritual can activate danger. We do not assume that a familiar religious form is safe merely because it is familiar. We observe the response and preserve choice.

7. Offer a response that is different but believable

A corrective experience must differ from the old prediction, but not so dramatically that it cannot be taken in. Grand reassurance may be dismissed. Steady, modest reliability is often more powerful: returning when promised, remembering the patient's concern, tolerating anger, not retaliating against refusal, acknowledging uncertainty, and remaining within role. The chaplain becomes trustworthy by behaving trustworthily, not by insisting that trust is warranted.

8. Notice repetition across relationships

What happens with us may be happening with nurses, physicians, family members, and other caregivers. We avoid forming coalitions around an untested interpretation, but we can contribute observations to interdisciplinary reflection: "He seems to become more guarded when several people speak at once." "She repeatedly agrees and later refuses; I wonder whether she needs more room to say no initially." Such observations are clinically useful because they describe patterns rather than assigning hidden motives.

9. Reflect on what the encounter leaves in us

After the visit we ask: What do I continue to feel? What scene stays with me? What action am I eager to take? Whom does this patient resemble? What outcome am I predicting? Did I become more certain than the evidence permits? Did I lose curiosity? These questions turn countertransference from an unexamined force into a source of disciplined inquiry.

Charting memory-informed observations

Clinical documentation should describe what the patient reports and what we observe without converting inference into fact. We chart: "Patient reported no recollection of the collision and became visibly tense when the monitor alarm sounded." We do not chart: "Patient has repressed the accident." We may write: "Patient stated, 'I know God is not punishing me,' while repeatedly returning to concerns about moral failure." We do not write: "Patient's punitive father is projected onto God" unless such a formulation belongs in a protected supervisory or clinical context and is clearly marked as tentative.

Memory-informed charting uses uncertainty honestly. "Appears," "may," "seems," "patient associates," and "patient reports" are signs of clinical accuracy, not weakness. The record should support continuity of care without hardening a provisional interpretation into the patient's official history.

Limits, referral, and interdisciplinary care

Chaplains work close to experiences that can evoke trauma, dissociation, cognitive impairment, and acute psychiatric distress. We need clear limits. We do not conduct forensic inquiry, diagnose neurocognitive disorders, undertake exposure treatment without appropriate training and role, or promise that spiritual

practices will recover or erase memory. We consult and refer when the patient is disoriented, at risk, persistently overwhelmed, unable to regain present orientation, or requesting treatment beyond our scope.

At the same time, referral does not mean withdrawal. The chaplain may remain part of the network of care: providing continuity, helping the patient articulate spiritual meaning, supporting consent and agency, participating in interdisciplinary formulation, and offering a relationship in which the person is not reduced to symptoms or history.

The clinical promise of a new experience

We cannot bring back every episodic memory, and we should not try. Some events were never encoded in a form available for autobiographical recall. Some details have been lost. Some experiences live primarily as meanings, sensory dispositions, emotional expectations, and procedures for surviving relationship. The inability to tell the story does not make the person unreachable.

Clinical chaplaincy begins with what is present now. A cue has meaning. A body prepares. A feeling arrives. A story is told or cannot be told. A religious image comforts or condemns. A relational expectation places us in a role. We attend to what is trying to become meaningful before deciding what it means.

The past cannot be changed as past. But the organism's use of the past is not entirely fixed. A prediction can meet a different outcome. A feeling can be borne in company. A refusal can be respected. A lament can be heard without being corrected. A person can discover that authority need not humiliate, that grief need not destroy relationship, that dependence need not erase dignity, and that the sacred may be encountered without coercion.

This is not magic, and it is not ours to control. It is the modest but consequential possibility that enters whenever one human being meets another with sufficient attention, role clarity, consent, steadiness, and care. The patient brings memory. The chaplain brings memory. Between them, something may happen that neither could have produced alone: an experience the future can remember differently.

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Note on the Figures

The figures are Clinical Chaplaincy teaching adaptations prepared in 2026. Source and adaptation notes appear within each figure. The memory-system maps are based primarily on Larry Squire’s framework, with the conscious/preconscious/unconscious annotations supplied by Mark Solms. The reconsolidation figures adapt Richard Lane’s integrated model. The predictive-processing figures draw on the work of Karl Friston and Mark Solms.

The brief clinical vignettes in this paper are composites created for teaching. They do not represent identifiable patients, family members, or staff.

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