

1.5 contact hours



When Memory Fails

Helping Dementia Patients Remember God

BY SHARON FISH MOONEY

Sarah, age eighty-two, had been a resident on the special care unit of the nursing home for seven years. Standing 4'8" and weighing 75 pounds, Sarah spent her days sitting in a chair next to the dining room door, frequently wringing

her hands and carrying on a steady one-way conversation with family members who were no longer living. Frequently, she would stand up, waver a bit, and then unsteadily make her way down the hall to her room. She would look in, turn around, and just as unsteadily make her way back to her chair next to the dining room door. With each trip Sarah had the curious habit of nearly running by the open door of a small bathroom situated two doors from her room.

Mornings Sarah generally appeared calm and her "family conversations" were quiet and relatively short, but by late afternoon her agitation would increase and the conversations with her "mother, brother and father" would become longer and more ani-

mated. Sarah also would direct her attention to other residents in the area, generally swearing at them or accusing them of wanting to kill her.

Sarah's agitation often continued through dinner, and a nursing assistant or nurse would sit next to Sarah to ensure that she ate. She would usually eat about half her evening meal, then sit in the dining area for an hour or so before being taken to her room where she was bathed, gowned and helped into bed. The nursing assistants were instructed to always leave the light on over Sarah's dresser. If they forgot, she would loudly yell out the name of her brother over and over, followed by "Help! Help! Help!" until someone came in and turned on the light. Sometimes she fell asleep, but often



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she would be helped out of bed again and assisted into a chair.

Little information was retrievable about Sarah’s past, though there was a notation that she had attended a Presbyterian church. There were no known living relatives, and no current information could be obtained other than from Sarah herself, who, because of her advanced dementia, was an unreliable historian. She knew her name and the names of some of her family members, but other “facts” changed on a daily basis.

My initial contact with Sarah came when I observed these behaviors as I was orienting to the special care unit. My involvement with Sarah came when I was working as evening charge nurse on the unit.

My evening charge routine varied little: report from 3:00–3:30 p.m., rounds to establish that, indeed, everyone was still on the unit and in no immediate danger or need, and then preparation for passing medications. This was the most disruptive time of day on the unit, when the condition known as “sundowning syndrome” or afternoon agitation and increased walking activity associated with dementia was at its peak.¹

This was certainly the case for Sarah. Her unsteadiness prompted concerns for her safety. One goal was to prevent her from falling, while still allowing her the freedom to continue her daily pattern of walking back and forth to her room. My solution was either to write “walk with Sarah” on

the assignment sheet or to walk with her myself. I frequently walked with her for at least five minutes and tried to communicate.

At first, Sarah resisted having company, and strongly resisted any attempt I made to physically steady her if she started to fall. She would swear at me and continue to carry on her one-way conversation with a relative.

I also became aware that when she would go by the bathroom door, which was usually open and dark, she would move closer to me, occasionally grabbing my hand just long enough to steady herself. When I asked her if she was afraid, she would emphatically insist, “No, no, no,” but her face and her behavior implied otherwise. However, the more I pressed to find out what she

might be afraid of, the more agitated she became. As we approached the bathroom door, I generally tried to distract her.

One evening, after Sarah had been helped into bed, I went in to check on her and found her wide awake. We had the following conversation.

N: Sarah, do you ever remember praying when you were afraid?

S: I guess so.

S: (no answer)

N: Sarah, I'm going to say the Lord's Prayer for you. Maybe you prayed that prayer when you were younger. "Our Father, Who art in heaven. Hallowed be Thy name. Thy Kingdom . . ."

S: come, Thy will be done . . . there . . . so there.

N: You remember that prayer, Sarah?

five minutes, as Sarah would sometimes begin at the beginning of the prayer and rework her way through it. After the final amen, Sarah sat up in bed, looked at me, said, "Thank you very much," lay back down and closed her eyes. When I stopped in fifteen minutes later, she was asleep.

Sarah was not the only resident in the nursing home who appeared to have both a behavioral and cognitive response to the sharing of a familiar spiritual ritual. Helen was another.

Helen, age sixty-five, was diagnosed with advanced dementia. She would spend most of her day wandering through the special care unit. She would seldom sit, though when she did, it was often on the floor. Like Sarah, late afternoon was when her agitation and restlessness increased, often manifested by Helen physically striking out at residents if they invaded her personal space and at staff if they tried to intervene. Helen's agitation was particularly acute following visits from her daughter; Helen always insisted she be allowed to go home with her daughter. Her daughter frequently left in tears or engaged in an argument with her mother.

One afternoon Helen saw the elevator door open and made a dash. She was restrained by two nursing assistants. After some effort, the assistants sat her in a geri-chair. Although she stopped kicking and struggling, it was clear her emotional distress was unrelied. Helen held her head in her hands, rocked back and forth in the chair and kept repeating, "Oh, no. Oh, dear. Oh, no."

On the unit at the time of this incident was a social worker who knew something about Helen's faith background. As we quickly brainstormed about possible solutions to Helen's agitated behavior, the social worker reminded me that Helen was

Spiritual rituals can result in concrete and visible physiological manifestations of decreased anxiety.

N: Do you remember what you were afraid of?

S: Him.

N: Who?

S: Oh, you know. That devil.

N: Do you remember why you were afraid of him?

S: (no answer)

N: Sarah, is the devil who you think you see in the bathroom? Is that who you are afraid of?

S: Don't know.

N: Sarah, you said that maybe you prayed when you were afraid. Do you remember what you prayed?

S: Come, come, come. Oh, shoot. Oh, Poo.

N: On earth . . .

S: Onearthasitisinheaven. So there. On . . . earth . . . as . . . it . . . is . . . in . . . heaven. Right.

Sarah continued praying with me. I would pause, and she would continue, sometimes saying, "Oh, shoot" or "oh, let's see now" when she was unable to remember a word. Sometimes she would run the words together and then carefully say them one by one.

We finished the prayer in about

@ a glance

- Dementia** describes symptoms caused by various diseases that affect or permanently damage brain cells
- The use of rituals** associated with Christianity can be an effective intervention for patients with dementia
- The Bible** offers insight into why religious rituals, sacraments and ceremonies are effective

Catholic and said she thought she remembered seeing a rosary in her room. We decided to explore the use of the rosary as an immediate intervention to decrease Helen's agitation. I retrieved the rosary and brought it to Helen. Her response was to grab it out of my hand and then to more carefully hold it, stroke it and begin to recite the rosary prayer. Within fifteen minutes, Helen was calm and I was able to carry on a lucid conversation with her about her family and her faith. When I asked if she would like me to pray for her, Helen readily agreed. She clutched the rosary in one hand and held my hand with her other hand. After the prayer, she was visibly calmer. Helen's use of the rosary and my use of prayer as a spiritual care intervention with Helen became a regular part of my evening routine on the unit. Helen also began to attend Catholic services in the home on a weekly basis.

MORE ON ALZHEIMER'S

Sarah and Helen were two of about thirty residents on the special care unit diagnosed with Alzheimer's disease. Alzheimer's is a type of dementia characterized by a gradual decline in intellectual functioning with a progressive loss of memory, first short-term and then long-term. Along with memory loss comes a mixing up of words and often a gradual loss of language ability. Alzheimer's disease (AD) is the most common cause of dementia, affecting approximately 4.5 million people in the U.S.² (See tables one and two for an overview of dementia.)

What causes Alzheimer's? Abnormal proteins collect in the brain and appear to cause loss of nerve cells in the areas vital to memory and thinking. Microscopic pathological findings of AD include development of senile or neuritic fibrous plaques and a starch-like amyloid protein that builds up

between nerve cells in the brain, inhibiting and scrambling messages. Neurofibrillary tangles that resemble twisted skeins of yarn also cluster in the nuclei of brain cells, further contributing to increased confusion, emotional lability and memory and language loss. The enzyme choline acetyltransferase and the neurotransmitter acetylcholine are absent or present

ALZHEIMER'S DISEASE AFFECTS:

memory of loved ones: It got to the point that my father didn't recognize my mother. He thought she was a stranger and would lock her out of the house. Twenty-four hours a day she had to wear a skeleton key around her neck.

language: Once in a while a word comes out I can understand, like, "Christmas," or a phrase like, "It's cold in here." But most of the time my husband just babbles. Sometimes we sit and babble together. I love to hear his voice. I dread the day when his babbling stops. Can you understand that?

personal identity: One morning my mother was sitting in her rocking chair in the bedroom while I cleaned out a closet in the hall. All of a sudden I heard her crying and rushed into the bedroom to see what was the matter. She was looking in the mirror, repeating the same phrase over and over again: "I lost myself. I lost myself."

Source: Sharon Fish. *Alzheimer's: Caring for Your Loved One, Caring for Yourself* (Colorado Springs: Shaw Books/WaterBrook Press, 1990).

MINISTRY OF MEMORY

The effect of Alzheimer's disease on spirituality, or on a person's relationship with God, is an area that has not been studied extensively. Experiences like the responses of Sarah and Helen to practices or rituals associated with Christianity and specific denominations, however, provide clues that this can be a fruitful area of research, as well

The Bible offers us insight into what could be described as "rituals for memory."

only in diminished amounts. Without this stimulus for neurotransmission, signals or messages are unable to move appropriately across the synaptic gap from neuron to neuron. This lack of communication, internal to the system, can result in inability to remember and to communicate verbally, if at all. Common medical treatments of Alzheimer's include cholinesterase inhibitors to increase acetylcholine, N-methyl D-aspartate (NMDA) antagonists and high doses of vitamin E (2000 U daily), which may offer neuro-protective features.³

as clinical practice and ministry for Christian nurses. For the present generation of older adults with progressive dementia, the importance of rituals as a means of enhancing some degree of orientation to reality, calming emotions and decreasing agitated physical behaviors should not be underestimated. What may actually be occurring *spiritually* may be more difficult to assess. However, the Bible offers us insight into what could be described as "rituals for memory." These insights can be used to develop a *ministry of memory* for those whose own memories of God

L e a v e s

*The woods are cold and silent,
waiting for snow
to adorn them with beauty,
welcoming winter.*

*I walk through the leaves,
scuffing my feet to hear
the last raspy sound
of their voices.*

*In spring the leaves,
lacy and freshly green,
whispered to each other
of rebirth.*

*All summer long
they murmured in the night,
rustled in the stiff wind,
talking to me in leaf language.*

*Now they lie here,
in the recycling of life,
obedient to the laws of Nature
who wastes nothing.*

*My leaf hangs loosely
on the tree of life.*

*Before I let go and fall,
may the last raspy
sound of my voice
praise you,
Lord of the leaves.*

BETTY JANE SANDERSON

and recollections of their relationship with him and with a fellowship of other believers may seem vague, at best.

“Memory,” wrote Kathleen Fisher in *Winter Grace*, “enables us to hold fast to our identity and shape it in new ways.”⁴ Yet when a person develops a

dementia, memory is often one of the first things they begin to lose. Remembrances of loved ones may be retained to a degree, though it is usually the memory of very early and close relationships rather than those of more recent origin. The name of one’s sister or brother may be remembered but not the name of one’s child. A spouse might be mistaken for a mother or a father and even called that. Eventually, one’s own personal identity may be forgotten. A response to the question, “What is your name?” is often answered by a person with progressive Alzheimer’s disease, “I don’t know.”

A biblical exploration of the concepts of memory, language and identity reveals that these three constructs are interwoven and are a rich source to draw from to understand how to more effectively care for and minister to people with dementia—especially those who have an established faith background.

In *The Dictionary of Biblical Imagery*, the editors note that “the biblical notion of remembrance extends far beyond nostalgic recall;” the goal of remembrance was, in fact, “complete obedience to God.”⁵ In both the Old and New Testaments the phrase “to remember” was an imperative or command and is often contrasted with forgetfulness. Forgetfulness, in fact, is viewed biblically as “one of humankind’s greatest spiritual maladies.”⁶ The people of God are continually cautioned and reminded to forget not God and his benefits (Ps 103:2), to take heed lest they forget the Lord (Deut 6:12), and to not forget God’s covenant (Ps 25:10) or God’s Word (Ps 119:16). In contrast, they are to actively remember the Lord himself who is their rock and redeemer (Ps 78:35), their creator (Eccl 12:1) and the doer of wonderful

works (Ps 104:24). Paul encourages Timothy, even as Timothy was to encourage fellow believers, to remember the risen Christ (2 Tim 2:8). Jesus commands his disciples to remember his word (Jn 15:20) and to let his words abide or dwell in them (Jn 15:7).

Throughout the Bible, the command to remember is frequently linked to the performance of a specific ritual, sacrament, ceremony or symbolic act. As God’s people responded in obedience to God’s commandments to do certain things, memory was jogged. Memories of past events in their individual and collective histories served to remind God’s people that in *all* times and seasons they lived, God remembered and rescued them (Ps 136:23–24), remembered his covenant with them (Ex 2:24) and remembered his steadfast love and faithfulness to them (Ps 98:3).

The book of Numbers provides an example of the need for remembrance and the importance of the observance of a ritual or symbolic act that seems to act as a medium through which memory is stirred, similar to the stimulus for transmission needed for healthy neurological functioning. The Lord himself spoke to Moses, telling him what to do in order to remember: “Speak to the people of Israel, and bid them to make tassels on the corners of their garments throughout their generations, and to put upon the tassel of each corner a cord of blue; and it shall be to you a tassel to look upon and remember all the commandments of the LORD, to do them, not to follow after your own heart and your own eyes, which you are inclined to go after wantonly. So you shall remember and do all my commandments, and be holy to your God, who brought you out of the land of Egypt, to be your God: I am the LORD your God. (Num 15:37–41, RSV).

In the foregoing passage, the Israelites are reminded of their identity as a holy people and of God's identity as their Savior and Lord.

Rituals of remembrance are evident in the Old Testament practice of the Passover (Ex 12) and in the New Testament sacrament or ordinance of the Lord's Supper or Eucharist (Mt 26); both are considered essential acts of remembrance. The act of doing or participating in a community of like believers is to be accompanied by a remembering of what God has done for them as Redeemer, bringing them out from physical and spiritual bondage. Both of these rituals are powerful reminders of God's sacrifice for a beloved people, prompting them to remember the blood of the lambs sprinkled on the doorposts and lintels of the houses at the Passover and the shed blood of Christ on the cross at his crucifixion. In addition, both rituals are sensory, involving taste, smell and touch, not merely intellectual experiences. Note that the ability to speak is not a necessary requirement; the ability to experience and receive is.

The entire Bible is a rich storehouse of memory aids or memory joggers. The psalms, especially, focus on the concept of remembrance. Many of the psalms are personal prayers of petition and intercession or supplication for forgiveness, grace and mercy or are hymns of praise and thanksgiving to God for what he has done. God often is individually remembered for deliverance out of dangerous and difficult situations and is collectively remembered for delivering his people as a body of believers. Remembrance in the psalms is both personal and shared.

Response to personal and collective memories of God's activity usually involves language or speaking

Table 1

about God. The writer of Psalm 111 says God has "caused his wonderful works to be remembered" (vs. 4). He views God as author of his memories, the shaper of his identity, and acknowledges this fact, verbally or in writing, with thanks and with praise. As people who are remembered by God remember God, the natural expression of that remembering is to give God glory.

In the New Testament, Paul reminds the Philippian Christians that as they literally remember God by rejoicing, petitioning and supplicating with thanksgiving, God's peace that passes all understanding will keep their hearts and minds in Jesus Christ (Phil 4:7). The word *dementia*, however, literally means "mind away" or "deprived of mind." How can this

peace be possible if the ability to remember, to rejoice, pray and to thank God independently, with cognitive functions intact, is significantly impaired?

Throughout Scripture, we see that God's expectations for his people are that they do remember and pray and praise, with the knowledge that they are redeemed and made in God's likeness. Is this expectation any less for a person beset by debilitating physical disease or by the mental disorganization that accompanies a progressive, irreversible dementia? The expectation in the Scriptures appears to remain constant, with *no* being the answer to the foregoing question. The means of achieving those expectations, however, may vary significantly.

James W. Ellor, in a chapter from

UNDERSTANDING DEMENTIA

Dementia is a descriptive term for a collection of symptoms that can be caused by a number of disorders that affect, and in some cases permanently damage, brain cells. Although common in very elderly individuals, dementia is not a normal part of aging. Serious forgetfulness, mood swings and other behavioral changes may be caused by poor diet, lack of sleep, medicines, loneliness, boredom, depression, etc. These problems are serious but often can be reversed.

Dementia is diagnosed only if two or more brain functions (i.e., memory and language skills) are significantly impaired without loss of consciousness. Symptoms include:

Significantly impaired intellectual functioning that interferes with normal activities and relationships

Loss of ability to solve problems and maintain emotional control

Personality changes/behavioral problems, such as agitation, delusions, hallucinations, inappropriate social behaviors

Stages of dementia include:

Mild cognitive impairment—some memory problems, but person can live independently

Mild dementia—impaired memory and thinking skills, may require assistance with finances, grooming/dressing, meal planning/ cooking, may become confused in public

Moderate dementia—severe memory impairment, difficulty communicating, can't live alone, can go out only with assistance

Severe dementia—severe communication problems, frequent incontinence, requires constant care, too impaired to go out alone

Profound dementia—person usually bedridden

Sources: National Institute of Neurological Disorders and Stroke - <http://www.ninds.nih.gov/disorders/dementias/dementia.htm>.

Alzheimer's Disease Education and Referral Center - <http://www.alzheimers.org/pubs/mid.htm>

MayoClinic.com - <http://www.mayoclinic.com/invoke.cfm?id=AN00208>

QUICK FACTS ABOUT DEMENTIA DISEASES, CAUSES, SYMPTOMS AND TREATMENTS

Disease: ¹ Causes/Risk Factors	Disease-Specific Symptoms (Sxs) ²	Treatments (Tx) ³
<p>Alzheimer's Disease (AD) [50-60% of all dementias]</p> <ul style="list-style-type: none"> ✓ Begins in medial temporal area and hippocampus of brain ✓ Progressive loss of brain cells; amyloid plaques and neurofibrillary tangles in brain ✓ Lower levels of choline acetyltransferase and acetylcholine in the brain ✓ Brain inflammation may contribute ✓ Onset usually after age 65; # of people with AD doubles every 5 years after 65 ✓ Family history predisposing factor 	<ul style="list-style-type: none"> ✓ Sxs develop slowly ✓ Begins with mild memory problems ✓ In late stages delusions and/or hallucinations; ends with severe brain damage ✓ Patients can live from 8 to 10 years after diagnosis but AD can last for as long as 20 years 	<ul style="list-style-type: none"> ✓ NSAIDs (Aleve, Celebrex) may slow onset but not delay progression after diagnosis; Vitamin E may offer neuroprotective features ✓ Early to mid AD: Cholinesterase-inhibitors (donepezil [Aricept], rivastigmine [Exelon], galantamine [Razadyne]) may help prevent some sxs from worsening for a limited time ✓ Moderate to severe AD: add N-methyl D-aspartate (NMDA) receptor antagonist (memantine [Namenda]) ✓ Other meds may help control behavioral sxs
<p>Dementia with Lewy Bodies (DLB) [15-25% of all dementias]</p> <ul style="list-style-type: none"> ✓ Presence of <i>Lewy bodies</i> (small, round inclusions found within nerve cells) in the brainstem and cortical areas of the cerebral hemispheres. (Lewy bodies also found with Parkinson's disease (PD), but primarily in the brainstem.) ✓ Progressive damage to brain cells 	<ul style="list-style-type: none"> ✓ Marked, persistent fluctuations in attention; visual hallucinations, extrapyramidal motor signs ✓ Repeated falls, unexplained syncope / loss of consciousness ✓ Delusions, sleep disturbances ✓ Sensitivity to neuroleptics 	<ul style="list-style-type: none"> ✓ May particularly benefit from cholinesterase-inhibitor therapy because DLB typically involves greater loss of acetylcholine compared to AD and has fewer neurofibrillary tangles ✓ Medical management of sxs
<p>Vascular or Multi-Infarct Disease (MID) [10-20% of all dementias]</p> <ul style="list-style-type: none"> ✓ Hypertension ✓ Other cardiovascular risk factors ✓ More likely in men ✓ Chronic condition with series of small strokes resulting in loss of brain tissue ✓ Area affected determines symptoms 	<ul style="list-style-type: none"> ✓ Awareness of deterioration; confusion; numbness, weakness; difficulty swallowing; aphasia, urinary incontinence; delusions ✓ Can develop, improve, stabilize, or worsen quickly 	<ul style="list-style-type: none"> ✓ Manage risk factors ✓ Prevention may involve aspirin, warfarin ✓ With known stroke event, Rx with tissue plasminogen activator within 3 hours can reopen vessels and may reduce severity
<p>Fronto-temporal Disease (FTD) (Pick's Disease) [3% of all dementias]</p> <ul style="list-style-type: none"> ✓ Gliosis (tissue scarring in CNS); vacuolation ("holes" in outer brain layer) ✓ FTD w/ Parkinsonism linked to mutation in tau gene ✓ Primarily affects frontal and anterior temporal brain lobes; progressive ✓ Usually develops between ages 35-65 ✓ 20-40% have family history of dementia 	<ul style="list-style-type: none"> ✓ Sxs depend on whether right or left brain affected ✓ Early sxs—behavioral, personality changes; hyperactive and apathetic; unaware of changes ✓ Later sxs—memory loss, oral fixation, repetitive actions, motor difficulties 	<ul style="list-style-type: none"> ✓ Currently, no Rx available to slow or stop the disease process ✓ Psychiatric meds can be used to treat some behavioral problems (SSRIs, newer antipsychotics) ✓ Practical strategies: make sure patient does not drive, avoid situations that call for financial decisions or judgment

Table 2a

the book *God Never Forgets: Faith, Hope and Alzheimer's Disease*, wrote the following, "If an older adult needs an amputation of a leg, the world knows how to respond. We help replace the lost mobility with crutches, an artificial leg or other alternative ambulatory devices. When a person is losing memory and cognition, we need to do similar things: find ways to use alternatives to memory and rational thinking. These people continue to be persons with souls. They are still members of the faith community. They call us to be cre-

ative in our ministry in ways that other members of the congregation do not require. This is an important challenge, not a burden."⁷

How does the emphasis on memory, language and identity specifically relate to and apply to people like Sarah and Helen, whose memories, speech and sense of self are slowly being swallowed in an ocean of forgetfulness? How can we be creative in our nursing care and ministry, both in our nursing roles and in our church congregations, to use alternatives to traditional conceptualizations

of memory and rational thinking? One important key to creative ministry is the use and practice of rituals, mediated through others on behalf of the person with memory loss.

USE OF RITUALS

In the Old and New Testaments, we find God actively ministering to people. God is to people what they lack. He is to people what they need. He does for people what they cannot do for themselves.

The Christian understanding of faith is that to the fatherless, God is

QUICK FACTS ABOUT DEMENTIA DISEASES, CAUSES, SYMPTOMS AND TREATMENTS

Disease: ¹	Causes/Risk Factors	Disease-Specific Symptoms (Sxs) ²	Treatments (Tx) ³
Huntington's Disease (HD) [rare]	<ul style="list-style-type: none"> ✓ Familial disease; 50-50 chance of passing from parent to child ✓ Juvenile onset before age 20; adult onset in middle age ✓ Degeneration of certain brain neurons from a programmed genetic mutation ✓ Earlier onset = faster progression 	<ul style="list-style-type: none"> ✓ Early sxs—mood swings, depression, irritability; trouble processing information ✓ With progression, increasingly difficult concentration, difficulty feeding oneself and swallowing, uncontrolled movements 	<ul style="list-style-type: none"> ✓ No Rx to stop or reverse HD ✓ Exercise and activity important ✓ Medical management of emotional and movement problems
Creutzfeldt-Jakob Disease (CJD) [rare]	<ul style="list-style-type: none"> ✓ Usually develops around age 60 ✓ 3 types: sporadic, hereditary, acquired ✓ Cause unknown but may be a type of protein called a prion which can be harmless or infectious ("mad cow disease") 	<ul style="list-style-type: none"> ✓ Early sxs—failing memory, behavioral changes, poor coordination, visual disturbance ✓ Mid to late sxs—pronounced mental deterioration, involuntary movement/weak, blindness, coma ✓ 90% of patients die within 1 year 	<ul style="list-style-type: none"> ✓ No Rx can cure or control CJD ✓ Sx management includes opiate drugs for pain; clonazepam and sodium valproate may help relieve involuntary muscle jerks
Binswanger Disease/Subcortical Dementia (BD) [rare]	<ul style="list-style-type: none"> ✓ Usually develops after age 60 ✓ Cerebrovascular lesions in the deep white-matter of the brain 	<ul style="list-style-type: none"> ✓ Strokes with partial recovery ✓ Loss of memory, cognition, mood changes, speech difficulty ✓ Abnormal B/P; blood abnormalities; disease of heart valves, large vessels in neck ✓ Urinary incontinence; slow, clumsy, lack of facial expression 	<ul style="list-style-type: none"> ✓ No Rx available to slow or stop disease process ✓ Meds to control high and low B/P, heart arrhythmias, depression

¹Definitive disease diagnosis can be made only upon autopsy. Other conditions that can cause dementia-like sxs are reactions to meds, metabolic/endocrine abnormalities, nutritional deficiencies, infection, poisoning, brain tumors, anoxia/hypoxia, heart and lung problems.

²Diagnosis of any dementia requires patient show sxs of cognitive impairment in at least 2 areas.

³All dementias benefit from practicing tasks to improve cognitive functioning (memory aids, note taking), especially in early stages of disease.

Sources: National Institute of Neurological Disorders and Stroke - <http://www.ninds.nih.gov/disorders/>
MedlinePlus - <http://www.nlm.nih.gov/medlineplus/ency/>
National Institute on Aging - <http://www.alzheimers.org/>

Table 2b

their father (Ps 68:5); to the widow or the abandoned wife, God is their husband (Ps 68:5; Is 54:5); to the sorrowful, their joy (Is 35:10); to the lost and seeking, their way and their truth (Jn 14:6). God, in Jesus, is to those who live in darkness, their light (Jn 1:1-5); and to those who need forgiveness, their redeemer (Col 1:14).⁸ God is their memory for those who are beset by seemingly unbearable burdens and may be unable to remember God and his promises. In Exodus, we read that the people of Israel were groaning under the bondage of the Egyptians and crying out for help. God heard their groaning and remembered his covenant with them. He saw them.

He knew their condition. He remembered them. He delivered them (Ex 2:23-25).

Dementia, too, is a type of bondage—a bondage of the mind. Sarah and Helen exhibited a type of emotional bondage accompanied by fears and frustrations, and accentuated, no doubt, by their unfamiliar surroundings and the loosening of familiar family ties. The use of a familiar, oft-repeated, and memorized prayer such as the Lord's Prayer and the customary practice of the rosary were examples of using rituals to help them connect on some level with past memories, deeply embedded and not totally forgotten. Sarah was able to pray the familiar prayer

herself, albeit haltingly, once the prayer was reintroduced to her in a time of need. Helen remembered, at some level, her own experience of reciting the rosary, recited for centuries by people of the Catholic faith to help focus attention on events in the life of Christ. Rituals and familiar practices within the rosary include making the sign of cross, the reciting of the Apostles' Creed and the Our Father (The Lord's Prayer), and prayers directed to God the Father, God the Son (Jesus) and Mary.⁹

"Anthropologists have long noted," wrote Garth D. Ludwig in *Order Restored*, "that rituals of healing play a dominant role in tradi-

SPIRITUAL RITUALS FOR USE IN A MINISTRY OF MEMORY

- Pray out loud with patient
- Provide opportunities for patient to pray aloud
- Read Scripture in response to assessed needs
- Ask patient to read Scripture aloud to you
- Develop familiar Scriptures you read to or recite with patient
- Discover and help patient recite Bible memory verses from the past
- Provide opportunities for participation in the Sacrament of the Mass, Eucharist or Communion
- Enable reconnection with established rituals of faith (the rosary, familiar hymns/songs, creeds)
- Regularly bring patient to worship services
- Arrange for regular visits from clergy

Table 3

tional societies.” He goes on to define a ritual as “a patterned, repetitive activity that conveys a meaning” for the people in that society. Rituals, he notes, are powerful and represent a group’s “shared values.”¹⁰ In addition to communicating “the deepest mysteries of faith,” they also “evoke within the person a sense of communicating with the divine.” Rituals “touch the emotions as few other social phenomenon do” and can be a “powerful means by which a Christian ministry of healing reaches out to the sick with the love of God and affirms these sufferers in their time of need.”¹¹ While healing rituals or practices like the laying on of hands, anointing with oil and healing-

tify in him. Furthermore, spiritual rituals can result in concrete and visible physiological manifestations of decreased anxiety, such as occurred with Sarah and Helen following their participation in nurse-initiated familiar rituals. These rituals also prompted Sarah and Helen to express prayer and praise to God with their own voices, fulfilling one of God’s purposes to remember him.

The ministry of God to persons with dementia must be the ministry of memory *for* them, and *with* them, reminding them over and over of how much God loves them, of what Christ has done (and is still doing) for them, and of who they are in Christ. This type of ministry can best be accom-

Rituals touch the emotions.

focused prayers, are more often associated with people with acute and chronic physical illnesses, these same rituals and others can be powerful means of reaching into the hearts and minds of people with dementia with the love of God, affirming their iden-

plished through rituals (see table three): by praying with these special people and providing opportunities for them to pray; by reading to them from the Scriptures in response to assessed needs like fear, guilt and anxiety and allowing them to read Scrip-

ture aloud to you; by providing opportunities for them to participate in Holy Communion, individually or in a group; by enabling them to reconnect with established rituals of their faith like the rosary and familiar hymns; and by bringing them to worship services that are places of collective memory where adoration, confession, thanksgiving, petition, supplication, and remembrances of God are shared in word and in song, acting in obedience to God.

■JCN

WEB RESOURCES

- Alzheimer’s Association - <http://www.alz.org/>
- Alzheimer’s Disease Education and Referral Center - <http://www.alzheimers.org/>
- National Institute of Neurological Disorders and Stroke - <http://www.ninds.nih.gov/disorders/cjd/cjd.htm>
- MedLinePlus - <http://www.nlm.nih.gov/medlineplus/dementia.html>
- Mayo Clinic - <http://www.mayoclinic.com/invoke.cfm?id=AN00208>

¹See Mayo Clinic, “Sundowning: Late Day Confusion in People with Dementia.” Accessed at <http://www.mayoclinic.com/invoke.cfm?id=HQ01463> on August 8, 2005.

²Alzheimer’s Disease Education and Referral Center, “2003 Progress Report on Alzheimer’s Disease.” Accessed at <http://www.alzheimers.org/pr03/01.htm> on August 8, 2005.

³National Institute on Aging, “Alzheimer’s Disease Medication Fact Sheet.” Accessed at <http://www.alzheimers.org/pubs/medications.htm> on August 8, 2005.

⁴Kathleen Fischer, *Winter Grace* (New York: Paulist Press, 1985), p. 34.

⁵Leland Ryken, James Wilhoit and Tremper Longman III (eds), *Dictionary of Biblical Imagery* (Downers Grove, IL: InterVarsity Press, 1998), p. 702.

⁶Ibid.

⁷James W. Ellor, “Celebrating the Human Spirit” in *God Never Forgets: Faith, Hope, and Alzheimer’s Disease*, Donald K. McKim, ed. (Louisville, KY: Westminster John Knox Press, 1977), p. 20.

⁸Sharon Fish Mooney, “A Ministry of Memory: Spiritual Care for the Older Adult with Dementia,” *Case Management Journals: The Journal of long-term Home Health Care*, 5, no 3 (Fall 2004): 183-87.

⁹As a Protestant, I have been involved in assisting with rosary services in long-term care settings and am at ease reciting portions familiar to me (e.g. The Apostles’ Creed; The Lord’s Prayer) and allowing the resident to remember and recite as much as they are able from their own memory, experience and denominational background.

¹⁰Garth D. Ludwig, *Order Restored: A Biblical Interpretation of Health, Medicine and Healing* (St. Louis: Concordia Academic Press, 1999), p. 217.

¹¹Ibid., p. 218.