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PASTORAL PRESENCE AND NON-VERBAL COMMUNICATION STRATEGIES FOR CHURCH MEMBERS LIVING WITH DEMENTIA

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Abstract
The purpose of this article is to provide effective non-verbal communication strategies for pastors (and laypersons) who have a genuine concern for dementia afflicted parishioners and loved ones. A persistent problem is that carrying out proper ministry to congregants with severe cognitive challenges is not an easy task, and because it is very difficult for pastors to help their dementia-diagnosed parishioners maintain consistent ecclesial involvement, patients often wind up entirely disconnected from church fellowship. In thesis form, congregants living with dementia are regularly marginalised from church fellowship, thus lacking Christian connection, often not receiving proper pastoral care, but this should not be the case, as biblically prudent ecclesial ministry necessarily entails providing a pastoral presence for those suffering from serious cognitive decline. Therefore, the theological analysis and literature review herein present clinically proven (and biblically supported) non-verbal communication strategies intended to improve the quality of ministry provided to Christian dementia patients. This research is significant in that it aspires to effectively help the numerous dementia sufferers who often go without proper care in the churches and at home.

Key Words: Biblical counselling, communications, dementia care, ecclesiology, pastoral ministry.

1.0 INTRODUCTION

Statistically, Alzheimer's dementia is a progressive and incurable disease, with about ten per cent of Americans over the age of sixty-five contracting the condition, and almost half of persons over eighty-five have the diagnosis. From the time that it starts until death, the disease lasts from two to fifteen years, although some people survive as long as twenty years or more with the condition (Collins, 2007). Dementia is hence adversely affecting elderly populations in the churches and should be considered a crucial counselling issue. Therefore, this paper explores unique epistemological considerations effective for reaching communicatively challenged persons that ontologically bear the image of God (*imago Dei; Gen. 1:27*) in their humanness.

Note well, dementia is an umbrella term used to generally categorise the symptoms of memory decline, distorted thinking, diminished judgment and reasoning abilities, focus and attention difficulties, as well as behavioural changes and problems communicating. Alzheimer's is a specific brain disease (one marked by symptoms of dementia) that progressively gets worse over time. Throughout this writing, the terms dementia, Alzheimer's, and senility are used synonymously. Relatedly, early-onset Alzheimer's basically refers to dementia patients who are younger than sixty-five years old, and late-onset Alzheimer's applies to those who are sixty-five or older. Both age groups experience the following symptoms: Progressive cognitive decline, severe language problems, difficulty calculating distances, and trouble navigating spaces. (Toyota et al., 2007).

2.0 LITERATURE REVIEW

Nouthetic counsellors Adams (1970, 1986) and David Powlison (2005) provide essential biblical perspectives on pastoral ministry, while Gary Collins (2017), Welch (1998), and David Hesselgrave (1987) offer broader Christian Counselling points to consider. The prolific research of John Swinton (2012, 2016) superbly integrates applicable medical case studies for dementia care, and Kitwood (2019) presents additional dementia-soul-care insights from a clinical/psychological standpoint. Carson (2004) helps theologically comprehend purposeful suffering, and the liturgical perspectives of Ames (1629) emphasise the mystical/transcendental aspects of the sacramental ordinance of communion, as partaking often renders a very positive effect on Christian's with dementia. Also, Goggin and Strobel (2017) and Udo Middleman (2004) effectively criticise overly secularised (i.e., "Professionalised") Western churches that simply drop the ball on pastoral care altogether.

Furthermore, Geisler and Boccino (2001) and Scott B. Rae (2018) articulate the ethical (imago Dei-affirming) considerations surrounding proper end-of-life Alzheimer's care. Moreover, J. P. Moreland (2000, 2021) and Roger Olsen (2018) guide pastors/ministers toward the (often overlooked) implementation of the supernatural (Spirit-led) aspects of divine healing in church ministry. And, the methods of Burke (2018), Mooney (2004), Owens (2014), Plunkett (2016), etc., provide excellent non-verbal communication strategies for implementation. This literature, employed in interdisciplinary synthesis, collectively presents a useful counselling blueprint that stands to greatly enhance (pastorally present) care for dementia sufferers.

3.0 METHODOLOGY

This study presents an overview and analysis of the circumstances surrounding Christian congregants with dementia, synthesising the fields of theology, liturgical studies, biblical counselling, sociology, communications, and medical field research. Diverse sources are compared from an array of ecclesial (and secular) contexts, as they support the involvement of Alzheimer's patients in continued relation to the churches. This method provides biblically based communication strategies to help pastors and church leaders (as well as friends/family) better serve loved ones who are neurologically atypical. For Christian leaders, the subsequent applied approach would be to refrain from keeping dementia-sufferers at arm's length, but rather to prioritise them when it comes to pastoral care and service ministry.

It should be a prose-form methodology of not more than 250 words, precise and comprehensive. Specifying the research design, all methods of data collection, sampling procedure, sample sizes and data analysis procedure.

4.0 FINDINGS AND DISCUSSION

In Evangelical churches in the West, pastors and leaders will oftentimes (even somewhat inadvertently) overlook providing proper care for congregants suffering from dementia. Such a lack of care has much to do with the struggles that exist in communicating with dementia sufferers. With biblical counselling being so discussion-oriented, when conversational challenges abound, church leaders are often prone to avoid providing pastoral care for Alzheimer's patients (and their families) who are members of their churches. This need not be the case, as employing some (even very basic) tried-and-true communications strategies can go a long way in this specialised vein of pastoral care.

It's a "Non-Casserole" Disease

Common perceptions of dementia portray it as an experience of fundamental crisis, both for individuals and their families, as images of frailty, despair, and a tremendous loss of autonomy abound. Sadly, the common metaphors used for those with the condition are at times pejorative. Disparaging terms such as the "erased hard drive," the "empty shell," or even "the living dead" are often imposed, conveying how dementia is negatively perceived in Western societal contexts (Krause, 2024). These stigmatised labels stem from the fact that patients regularly experience extreme personality changes, becoming socially strange (or even unrecognisable) to themselves and others in comparison with the ways in which they were at previous points in time (Swinton, 2016). Sharon Mooney (2004) stresses that at the core of persons with Alzheimer's dementia is the very loss of self, a loss that occurs when "the sense of personal identity and the memories that shaped it have gradually become swallowed up in a sea of forgetfulness."

Mooney (2004) furthers that both early-onset and late-onset Alzheimer's are mind-altering diseases characterised by a continuous decrease in intellectual functioning with a gradual loss of memory. Personality changes and difficulty with abstract thinking and orientation are also primary symptoms." The cognitive decline is increasingly obvious in the advanced stages, as otherwise simple, everyday tasks become major life challenges. Edward T. Welch (1998) explains that a dementia diagnosee may have difficulties recognizing and interpreting previously familiar objects, such as a bathroom shower head, and a simple shower may be misinterpreted to be a severe rainstorm, causing them to frantically seek to escape to a safe place; therefore, self-care "is increasingly difficult," says Welch, "and the person eventually needs full-time supervision."

Dementia sufferers are also commonly marginalised from the workplace, community activities, social events, and even family functions. John Swinton (2012) portends that this exclusionary "malignant social positioning" results not only from having the condition, but also from the stigma that comes with the diagnostic label. In the church context, dementia could thus be informally classified as a Non-Casserole Disease. That is, if someone has a broken leg or is going through chemotherapy, fellow church members customarily bring casserole dishes over to their house as a gesture of support. But if a parishioner suffers from clinical depression, is paralysed by anxiety, or has acute Alzheimer's, then no casseroles are delivered, as interacting with stigmatised mental conditions is often avoided, sometimes even by church leaders (Wurtman, 2018). The shunning attitudes of the fellowship may be internalised by the family caregiver, who then decides that the person is no longer capable of participation in worship services.

The misunderstandings run deep, as churches may assume that a dementia patient is receiving no benefit from attendance due to erratic behaviours such as dozing off, wandering around, or expressing agitation. The family decision to remove them from the assembly (contra Heb. 10:25) would reduce opportunities for social interaction and regular stimulation, causing a further decline in mental health (Ryan, 1995). It is therefore crucial for pastoral leaders to understand that dementia-affected parishioners need to be recognised as something more than their diagnosis (C. Collins, 2017). They need social attachments to maintain bonds and feelings of security, to retain connection with others, and to continually be included in ecclesial life and ministry service (Burke et al., 2018).

Applied Theological Considerations

An important theological aspect to consider about human beings is that they are created in the image of God (imago Dei: Gen. 1:27), and the fact that a person bears this image is the basis for his or her dignity. According to John S. Hammett (2007), a correct understanding of this is at the centre of truly Christian human relationships. Man was made with a social nature (Gen. 2:18), even as God has a social nature (Zeph. 3:17; Ps. 73:23-26). And, biblical affections and social interests spring directly from this intrinsic element in humans. Created as sentient, social, and spiritual beings, humans are not isolates (Prov. 18:1), and they are fundamentally persons in relationship (Prov. 27:17). God has endowed man with a social nature, and, consequently, man seeks companionship (Thiessen, 2006). Towards Christian counselling, David Hesselgrave (1987) says that at the heart of personal wholeness "are right relationships with God, other men, and the self."

Further, the fundamental principle in counselling is God's very existence (Is. 46:9-10), specifically that of his omnipresence (Ps. 139:7-10). On the one hand, he is transcendent, dwelling outside time and space (Is. 57:15), sovereign over his creation (Ps. 103:19), and separate from it in his being and his holiness (Ps. 97:9). On the other hand, God is near to his children (Gal. 4:6; 1 Jn. 3:1) and as close at hand as a loving Father (Rom. 8:14-17). As the Eternal Counselor, he is a Father to the fatherless (Ps. 68:3-6) and the source of all human life (Acts 17:27-28), dwelling "in the midst of the camp" (Miller, 2018) and in the midst of our daily lives (2 Cor. 6:16). The related ministry applications are that the Triune God is ever-present with believers who suffer from dementia (Is. 40:29), and that God spiritually empowers pastors to effectively minister to afflicted congregants in need (Acts 20:28; Eph. 4:11-12).

Personhood-Affirming Pastoral Presence

Thus, a faithful shepherd should carry a tangible pastoral presence (Ez. 34:11-12), especially with those suffering from cognitive disabilities. According to Joe Trull and James Carter (2004), proper pastoral care necessarily entails a robust relational presence: "No matter how competent church leaders may be in regard to biblical exposition, grasping church growth principles, and the intricacies of organization, they cannot adequately minister without good relationships with church people . . . Through compassionate care and genuine concern, the minister lets people know that they are meaningful and important." Jamin Goggin and Kyle Strobel (2017) stress that a healthy shepherd gives their life for the sake of the flock, embraces their congregation as people to know and love, viewing prayer and care as the centrepiece of their work. The faithful pastor seeks to be relationally proximate to his parishioners (1 Pet. 5:2).

In his seminal work on dementia, Tom Kitwood (2019) emphasises the relational aspect of personhood as "a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being." Personhood-affirming counselling strategies advancefrom the perspective that someone has value simply because they are created in the image of God, and that a medical diagnosis of dementia does not diminish their personhood (Ryan, 1995). Although personhood in people with dementia is increasingly concealed, it is not lost. Acknowledging them as God's image-bearers moves us away from errantly reading their lives through the lens of their diagnosis (Swinton, 2012). This approach focuses on the beloved child of God with the intention of showing them love, care, and concern in the name of Jesus Christ. The goal of pastoral care then becomes one of presence and being, rather than progress and doing (Ryan, 1995).

Overcoming Communication Barriers

In dementia ministry, complex communication barriers are unavoidable, as the flow of conversation can range from very difficult to practically impossible in the later stages (Kestal, 2009). The following questions from Frances Schaeffer (1968) actually flesh out the core pastoral challenge: Why wouldn't God "communicate in verbalized form when He has made man a verbalizing being, in his thoughts as well as in communication with other men?" and, "Having created man in His own image, why should He fail to communicate to that verbalizing being in such terms?" These questions express some rather straightforward theology regarding the transmission of God's message (verbalised to humans) contained in the Holy Bible (Ps. 32:8; Jn. 8:48). But, what about atypical instances where verbal communication is at best minimal, and at worst non-existent? In short, our beloved non-verbal congregants pose tremendous challenges for pastoral care.

As a particular example, a minister in training once asked the following revealing question about dementia ministry: "How can I provide pastoral care when the patient cannot carry on a decent conversation?" (cf. VandeCreek, 1999). The question is an honest one, actually, and could just as well be posed by a seasoned pastoral minister. A healthy, experienced shepherd would hardly argue against ministering to the dementia-afflicted, but they simply might not know how to overcome the attending communication barriers. With counselling sessions being so conversational and creeds and confessions at the forefront of Western ecclesial practice, not being able to converse back and forth with an ailing parishioner throws a wrench in the pastoral gears. Notwithstanding, when pastors avoid communicating with the cognitively

challenged, "there can be a persisting isolation and loneliness even when these individuals are surrounded by others" (Collins, 2007).

The common communication barriers are not insurmountable, though, as according to Welch (1998), "even with severe cases the dementia patient maintains a conscience, and an ability to respond to God, and an ability to turn from sin. The challenge is to communicate God's truth in a way that is understandable and memorable." Therefore, the diminishment in communicative abilities necessitates substantial ministerial adaptations (cf. 1 Cor. 9:2–27) in order for people with dementia to receive effective counselling and participate meaningfully in spiritual activities. A beneficial first step here would be for pastors and counsellors to consider employing biblically supported, nonverbal communication strategies that are quite useful in ministering to dementia patients.

Nonverbal Communication and Alternative Conveyances

Biblical practices and perspectives are frequently retained in long-term memory and therefore need to be drawn out of the dementia counselee (Hawkes & Taylor, 2024). But how? Swinton (2016) advances that creative stimuli such as music, smell, and visual aids can help refresh important memories, effectively functioning "as bridges that temporarily heal the neurological fracture and enable people to access memories that they are unable to access through other means."He further recommends remaining open to the possibility "that our touch, the sound of voice, the smell of perfume, or the music that we bring to the individual can actually bridge the gap, even if that bridging lasts only for a few moments" (Swinton, 2016). The goal here is to provide what David Powlison (2005) calls a "small counselling moment" where our interest and words can be grace-giving. Further, according to Ryan (1995), given the maintenance of nonverbal comprehension and expression in dementia care, it is also useful to focus on the pronounced nonverbal cues, "especially tone of voice, eye contact, timing, facial expressions, gestures, body postures, and touch."

Non-verbal communications are not out of the scope of biblical counselling. Adams (1970) expresses the importance for counsellors to learn to read faces, actions, and gestures. The Apostle Paul's ability to interpret nonverbal feedback is noted, for instance, in Acts 14:8-10:

Now at Lystra, there was a man sitting who could not use his feet. He was crippled from birth and had never walked. He listened to Paul speaking. And Paul, looking intently at him and seeing that he had faith to be made well, said in a loud voice, "Stand upright on your feet." And he sprang up and began walking. (ESV, emphasis mine).

Paul, in the midst of a crowd (while preaching) was able to single out one man who had faith to be made well by "looking intently at him." (v. 9) Seeing that he had faith, Paul said, "stand upright on your feet." (v. 10) Here, Adams (1970) emphasizes the non-verbal cues, as "there comes a point when a good counselor can see that the client is ready to make a decision or to take an action. Sometimes the whole demeanor of the client signals this. Often some particular element of that demeanor gives the clue (such as frowning or hesitation indicating decision making). At this point the counselor, like Paul, ought to challenge the client to take the next step in faith."

Creatively effective nonverbal strategies should also be implemented by the counsellor. Ryan (1995) explains that even the most severely cognitively ill can experientially recollect God's presence through sensory experiences that are richly symbolic, such as the aroma of freshly baked bread, and the smell of the earth on a crisp autumn day or the caress of a warm summer breeze not only stimulates the senses, but also celebrates the relationship with God and his Creation (Ps. 19:1-6; Rom. 1:20). Such sensations can renew a state of theological reflection through a sentient mode of conscious awareness of the sounds, temperatures, colors, or smells that might bring about a biblical recollection. Some of these sensations are experiences of things outside the person, like sunlight or a familiar church building (Moreland & Rae, 2000). Others are cognisant awarenesses of emotional states within themselves, like happiness or joy in the Lord (Ps. 16:11; Rom 15:13).

Another counselling consideration is that touch and taste are the most direct of the stimulus examples. As James Dew and Mark Forman (2014) explain, unlike seeing, hearing, and smelling, the perceptions of touch and taste seem to be more direct and immediate, and are thus good examples of a two-part kind of perception. Hence, when a counsellor reaches out and touches the client's hand, they are really (directly, immediately) touching their hand (Dew & Foreman, 2014). This kind of perception does not require some third object like sound or light waves to make it possible. For instance, when a dementia sufferer simply eats a cookie, the taste of the sweetness of sugar and chocolate is a direct and immediate sensation (Dew & Foreman, 2014). An action proposal would be for a pastor to discover a long-time favourite food of the counselee, hospitably serving them a portion in hopes of stirring up some familiar biblical recollections and memories of God. Moreover, selecting a special location such as a favourite eatery or picnic spot could be effectively stimulating. For example, ministers and/or family members taking the dementia patient to a specific restaurant that they always liked to go to after church could help with spiritual recollections.

Regarding church ordinances, the ingestion of communion elements (bread and wine/juice) is an additional example, as this New Testament ordinance is an act of remembering Christ's death. In fact (cf. Mooney, 2004), it is an actual proclamation of that death (1 Cor. 11:26), entailing the intimate identifications of the believer with the blood and body of Christ (1 Cor. 10:16–17). In the communion sacrament, there is something recollectable to the senses as well as something spiritual. As Scholastic Reformer, William Ames (1629) explained, "A sign is something perceptible to the senses which, beyond the appearance of the thing it brings directly to the senses, at the same time makes something else come into the mind;" Ames hence considered the mysterious role/sign of the sacrament to be as far-reaching as that of a logical argument, as it is "a divine institution in which the blessings of the new covenant are represented, presented, and applied through signs perceptible to the senses."

Dementia sufferers should therefore be encouraged to partake in the Lord's Supper in order to experience the mystical application of God's grace and favour that is brought to remembrance and reconfirmed in the patient's memory by the sacrament. Pirhonen et al. (2024) emphasise here that the ministry of God to Christian persons with dementia must be the ministry of memory for them; thus, reminding them over and over again of how much God loves them, of what Jesus has done (and is still doing) for them, and of who they are in Christ. This can be accomplished by enabling them to participate in communion, either at a church service or brought to them by an ordained pastor, hence ushering them into a place of worship in a safe, unencumbered, experiential space.

Also recommended is to bring several people from the congregation along to the care facility to join them in communion while also encouraging the singing of familiar songs and hymns. According to Melissa Owens (2014), "It is not uncommon for those with mild to moderate dementia to sing. This is true even when recall does not occur within the context of conversation." It is also beneficial to remind patients of key Bible stories when conversation opportunities do arise. Ryan (1995) suggests tapping into the metaphorical strength of familiar Parables and Psalms to help reflect on the meaning behind life events, or to take comfort in recognisable words and rhythms. Furthermore, encouraging the patient that they are not alone, reminding that Jesus is with them, sharing simple statements like, "If you are feeling frightened or isolated, just call on the name of Jesus, as He is with you always" (Matt. 14:22-33; 28:20; Heb. 13:5). These are very, very simple terms, but they communicate basic biblical perspectives that often resonate well with dementia patients (Hawkes & Taylor, 2024).

Westernisation and the "Postmodern Pastor"

Towards an additional default category of dementia patient marginalisation, Wells (1993) details at length how the postmodern individualism, consumerism, selfism, and professionalism of the West have adversely affected the evangelical churches in America. This is evidenced by many "secularised" pastors who are more concerned about elevating their vocational status in the community instead of ministering to the congregation (Wells, 1993). Goggin and Strobel (2017) identify such "leaders" as those who are fixated on the spectacular, obsessed with recognition and validation, and intoxicated by fame and power. These "professionalised" CEOs use the church as a platform for personal fame, fortune, and influence. The congregants are merely seen as tools to accomplish their big dreams (Goggin & Strobel, 2017). These negligent non-leaders will receive severe judgment from God (Ez. 34:1-10).

In the meantime, they rarely do any substantial counselling at all (typically not providing any dementia-specific care), and only offer shallow self-focused messages, rather than biblical/exegetical perspectives that sanctify. Middleman (2004) emphasises that seeker-sensitive, 'professionalised' pastors often intentionally adjust their sermons "to match the perceived needs of future possible converts [and that doing so] eats away at the content necessary to understand God, the fall of man, and redemption." Thus, the sermon produced "is matched to the customer's expectations," and, as such, there is little room in these messages "for God to set forth judgement and [the necessary] conditions for redemption" (Middleman, 2004).

Much of the lack in dementia care can be chalked up to the postmodernist church tendency to refer pastoral counselling to Christian therapy centres. Adams (1986) avers that churches have a general propensity to outsource care, as counselling and works of mercy are "all but forgotten by many Bible-practicing churches and barely acknowledged by others." That is, in our American environment of insurance, social security, and Medicaid, there is a tendency to refer to outside "experts," but external counselling centres "cannot do what God told the church to do" (Adams, 1986). Powlison (2005) warns against such deferences, as "There is a built-in pressure on Christians who are psychologists to deviate from Scripture." Instead, Powlison (2005) recommends seeing a non-professional counsellor, as in his estimation, "A non-psychologist is often more insightful and helpful than a psychotherapist."

Basically, the problems psychologists address are the same ones that the Bible addresses, so a minister well-versed in the Scriptures stands to have better counselling success. Nevertheless, even if the treatment

centre referred to offers good biblical counselling (which is often not the case), there is still a resulting lack of person-to-person pastoral presence, one that intentionally endeavours to 'seek that which is lost' and thus minimise the dementia sufferer's isolation (cf. Luke 15:3-7). A pastoral attendance that also encourages the patient (and his/her family) to remain active in Church and ministry service (Heb. 10:25; 1 Pet. 2:9).

The fast-paced modernisation of the West adversely affects the dementia patient in a direct sense as well. That is, in a technocratic world that adores speed, exalts quickness of mind and intellectual prowess, and worships comfortably at the altar of competitiveness, productivity, efficiency, and self-sufficiency, the dementia sufferer is castigated as one who steps much too slowly and lives at a pace far too out of time (Swinton, 2016). The secularist worldview implication, according to Swinton (2016), is that to live humanly is to live out one's life effectively according to "a series of culturally constructed time tracks that are laid out according to the fixed and relentless rhythm of the clock or the watch." Not to be able to move one's body or mind to such a temporal rhythm, "is to live in a way that pushes the boundaries of acceptable humanness" (Swinton, 2016). The problems that this raises for people with advanced forms of cognitive disability are obvious.

Dementia drastically slows a person down and leads to a severe loss of episodic memory. Kenneth Roxburgh (2000) adds that if we assume that memory is equal to identity, then the loss of this aspect of our memory will inevitably be perceived as leading to a loss of self and self-identity. Memory understood in this way raises profound questions. What is it that gives a person his or her continuity of identity? What is the connection between what they were when they were a remembering being and what they are not now that they have forgotten what they were? (Swinton, 2012). Dementia senility raises serious questions about what constitutes a person and what the Bible means when it speaks about humankind being created in the image of God. This is not merely an academic question, says Roxburgh (2000), for unless we see those who suffer from dementia as radiating the imago Dei, then we are unlikely to look after them with the same love, care, and attention which they deserve and which God's word demands. (cf. Ps. 82:3-4; Prov. 31:9)

Living in the Memories of God

A person's relationship with God has first priority. When one stops to think about it, as Hesselgrave (1987) explains, the command to love God carries with it the possibility of knowing and loving him. This is certainly the highest and noblest privilege a person possesses. The implication is that no pastoral counsellor can understand a human being unless he sees him in relation to God. What is more, it means that no pastor can help a human person (in any ultimate sense) unless he sees that person in relation to God (Hesselgrave, 1987). As Adams (1986) theologises, God is around us, in us, and with us. He knows and cares about every word on our lips and every thought in our minds. He knows us and indeed has known all about us from all eternity past. The omniscient, omnipresent God is our environment—inescapably so. And although most people rarely recognise it, they are deeply influenced in all their thoughts and actions by their environment (Adams, 1986). A goal in ministering to a parishioner with dementia, then, is to employ biblical modalities of nonverbal communication (i.e., familiar music and food, partaking in communion, etc.) to help them recall the theistic life-context aspects already residing deep inside of their memory banks.

What is of utmost importance is that those with dementia are remembered by God. And, if their identity is held in and by the memory of God, then we can be certain that dementia does not destroy them now or in the future. Swinton (2012) theologically emphasizes that living in the memories of God (Is. 49:15-16) also entails the promise of everlasting and enduring hope (2 Cor. 3:12-18; Titus 2:13). Moreover, if being remembered by God also indicates (and indeed necessitates) some form of action in the present, "then presumably God is doing something right now in the lives of people with severe dementia" (Swinton, 2012). One of these 'doings' relates to the work of the Holy Spirit, "as God is with the person who has dementia in ways that we cannot know;" therefore, Swinton (2012) concludes that this mysterious dimension can only be grasped by faith, as "We trust that God is with and for the person even if we have no real idea what that might mean."

Family and Church Ministry

For the family, it is possible that the most difficult part of dealing with dementia is the patient's emotional unpredictability. Welch (1998) explains that diverse emotions can fluctuate from anger, suspicion, and depression, to alternating episodes of silliness and childish elation, all without any given notice. Family members are frustratingly perplexed, angry, and guilt-laden as they are haplessly swayed by these turnabouts. This stage is often when families realise they need to be educated about cognitive decline and Alzheimer's disease (Welch, 1998). During this time, the family should be reading everything they can about these conditions. With the help of good available literature, local support groups, and biblical studies on the elderly and honouring parents (Ex. 20:12; Lev. 19:32; 1 Tim. 5:1-2; 1 Pet. 5:5), family caregivers can be in a better position to understand the atypical behaviours associated with dementia and thus grow in their faith.

As Alzheimer's sets in, families must begin looking toward other family members, the church, and perhaps community resources for assistance. The church's participation can be invaluable. Along with providing encouragement and counsel, deacons and friends can provide supervision during nights or weekends away. Consider also the priesthood of all believers (cf. 1 Pet. 2:9). Within a healthy church, everybody has a place and an active ministry vocation in the fellowship. As Swinton (2016) avers regarding lay 'priesthood' dementia care, "such vocations stretch our ecclesial imaginations in powerful and deeply healing ways. Being cared for by a member of the church can be a fulfilment of one's humaneness." Counselling with the elderly, therefore, is likely to be most effective if family and/or church members are involved. Here, then, the pastoral counsellor may serve as a mediator, helping resolve intergenerational conflicts.

The counsellor sometimes provides information to family members, giving practical suggestions for managing unusual behaviour, getting medical treatment, deciding on appropriate living accommodations, and handling finances (Collins, 2007). When an older person is resistant to pastoral counselling, the only way to get help may be through family members. The family can then make plans for the future, support and encourage one another, and cope with their own grief or guilt. Financial management poses another problem. If the person with dementia is the household financial manager, a spouse or relative will gradually have to perform that function. Paying bills, balancing chequebooks, locating important financial documents, and reviewing wills are all part of this financial package. At this stage, legal advice is helpful (Welch, 1998).

A City Without Walls

"Whoever has no rule over his own spirit is like a city broken down, without walls" (Prov. 25:28). Surrounding the dementia diagnosis, the walls of self-control are weakened. And, with one's cognitive "city broken down," whatever was thought or verbalised in private is now public, as the patient can no longer distinguish between the two. This is certainly a sobering thought, avers Welch (1998). What would it be like to have our private lives broadcast to our family and friends? Sexual thoughts, jealousy, private profanity, and anger can be neatly covered when our minds are intact. But when we are intellectually less competent, some of these private events begin to slip out. This is what Welch (1998) refers to as "increased exposure of the secret ways of the heart."

Counselling essentially entails aiding patients in their thinking, feeling, and behaviour in accordance with God's word concerning the human problem and divine solution (Hesselgrave, 1987). Pastors and/or family members can share the truth in love (Eph. 4:15) and, with gentleness and respect (1 Pet. 3:15), tell the person with dementia that certain behaviours are wrong. There is no need to point out every sin all at once, but to speak out against foul language and inappropriate comments is biblical (Eph. 4:29). When done so in a loving manner, it could be surprising how responsive and apologetic the loved one can become (Welch, 1998). Swinton (2012) recommends organising a team effort, "as when a person with dementia progressively loses the ability to sustain their roles in society, it becomes the responsibility of those around them to tell their story well and to sustain them in their identity and communal representation."

Never a Leper: Overcoming Social Isolation

The gospel account of Jesus compassionately healing a leper (Luke 5:12-16) offers a touching image for the pastoral care of people in cognitive decline. Whether they are residing in care centres or living at home, dementia sufferers, like lepers, are increasingly isolated from the church community (Kestal, 2009). As they sink further into cognitive decline, interaction with family, friends, and the church fellowship becomes more difficult. At some point, the individual is no longer able to attend Sunday services. Memory loss and decreased ability to communicate make it difficult for family and friends to spend time with and/or talk to the person. Kestal (2009) explains that, like the leper, the dementia patient gradually becomes out of the sight and mind of the church. When the leper approaches Jesus and asks for help, Christ listens and responds with comforting words and a connecting human touch (Kestal, 2009). Towards application, David (2005) stresses that "Pastors are called to lead in the example of compassionately helping people in the name of Jesus."

Family caregivers are also in great need of this compassionate pastoral care. Some of the loneliest people on earth are those who look after their loved ones with dementia. Accordingly, Gary Collins (2007) explains: "As the years pass and the condition worsens, loneliness in the caregivers often increases, depression appears and gets worse, and other relationships suffer." For those bearing the burden of care-giving, there is the unrelenting cycle of work, responsibility, and duties which overwhelm one's personal enjoyment of life, instead overcoming them with feelings of anger and resentment as they become "weary in well-doing" (cf. Gal. 6:9). Here, Roxburgh (2000) underlines the sorrow of bereavement, "because the person you once knew has seemingly been lost, and yet in this situation, they are still alive." For family members who cannot be caregivers for a variety of reasons, reluctantly having placed their loved one into a nursing home, "there may be deep feelings of guilt and selfishness" (Roxburgh, 2000).

Regretfully, there is no cure for the mental or physical diminishment of dementia, but ensuring good pastoral care can help to make the church more present to the patient as well as make the patient more present to the fellowship. As Kestal (2009) proclaims, "I believe this presence of the community and presence to the community can bring the healing word and touch of Jesus to the person suffering from dementia."

A Biblical Perspective of Suffering

We know the Apostle Paul says that for those who love God, "all things work together for good" (Rom. 8:28). But, how can any good be 'worked' in the midst of dementia suffering? There is no attempt anywhere in Scripture, says Carson (2004), to whitewash the anguish of God's people when they undergo suffering: "They argue with God, they complain to God, they are weak before God. Theirs is not a faith that leads to dry ice stoicism, but a faith so robust it wrestles with God." Even believers who are very mature in their faith may question how God could allow certain tragedies and illnesses to happen to them (Wright et al., 1985). They may consider it a terrible sin to be angry with God, or they may fear they have lost their faith. Such feelings could deprive them of the strength and reassurance faith offers at just the time when they need it most. As Carson (2004) encourages, though, "To struggle with such questions is part of the experience of faith."

Powlison (2005) explains that it makes a difference whether or not you interpret "abilities" and "disabilities" as gifts of God; the biblical perspective is that Down's Syndrome, Asperger Syndrome, Alzheimer's, and other "disabilities" all occur within the divine providence of God (Gen. 50:20; Ex. 4:11). A skeptic might ask: Do Christians affected by such illnesses really develop steadfastness, character, and hope as a result? (Rom. 5:3-5). Here, a caregiving daughter of dementia sufferers affirmatively testifies: "I would not have given up this period to care for my parents for anything. There has been combativeness, wandering, and lots of frustrations. But I'm learning for the first time to take each day at a time. It has been the richest time of our lives—not moneywise, by far—but in emotional and spiritual growth. This illness in the family is teaching me to gain strength from the Lord—and His instruments" (cf. Wright et al., 1985).

Is a Divine Healing a Possibility?

Although Alzheimer's disease and attendant dementia symptoms are irreversible, there are ways to slow the progression of the disease and optimise quality of life. For example, to achieve optimal daily well-being, individuals living with dementia can implement several strategies. These include having routines and reminders, maintaining personal care, ensuring safety, obtaining reliable transportation, staying active, getting adequate sleep, and standardising meal times (Plunkett & Chen, 2016). The cognitive health-maintenance benefits of such structures and natural practices notwithstanding, is it possible for a dementia sufferer to be entirely healed from their condition? The short biblical answer is, of course: 'Yes, and amen!" (Ps. 41:3; Matt. 10:1)

Nevertheless, according to Moreland (2021), secularism diminishes and eliminates the miraculous, and Western Christians have absorbed more of the secular worldview than they like to admit, as many evangelicals find miracle stories rather hard to believe or even embarrassing. Hence, our focus is often placed squarely on the natural world, with little or no attention paid to the supernatural world (Moreland, 2021). Therefore, even otherwise relatively solid pastors have relegated miracles (such as divine healings)

to biblical times, or they place them somewhere else "out there on the mission field," rather than seeing them as an ever-present possibility. Roger Olsen (2018) explains that this is obvious from the way we react when someone falls ill: "Of course we pray for them, but what do we ask? That God would comfort them in the midst of their suffering, that he would guide the hands of surgeons, and give doctors enhanced wisdom and discernment. But what is usually missing is asking God to supernaturally heal them."

The Bible says to lay hands on the sick (Mk. 16:18), pray for their healing, and anoint them with oil (Jas. 5:14-16), but mainstream evangelicals often look down their noses at churches that do so (Olsen, 2018). They suspect such churches are cultic or that they discourage people from seeking medical help. What is more, Western evangelicals often avoid any mention of demons, and they shun exorcism as primitive and superstitious–unless Jesus did it (Olsen, 2018). Why is this important for pastors to consider? Well, such Christian naturalism should be avoided, as it very well could be that someone who is showing severe signs of cognitive distortion is actually demon-possessed (as an unbeliever) or demonically oppressed (in the case of a believer). Also, in confirmed medical cases of dementia, it is entirely possible that God could completely heal the person through prayer.

In fact, there are currently numerous dementia healing testimonies available for public review. For example, Pastor Rob Chaffert (Healed of Dementia, sermonillustrator.org) proclaims that he had been clinically diagnosed with dementia by a doctor, but then, after fervently praying and seeking the Lord, he and his wife noticed a drastic turnaround in his cognitive abilities. Upon returning to the same physician, the reversal of symptoms was confirmed, but the doctor sceptically concluded that Chaffert must not have had dementia in the first place (i.e., a case of misdiagnosis). In another case, after the church board asked Pastor Richard Skoff (2015) to step down from ministry due to his severe cognitive decline, instructing him to get a thorough medical examination, he was then diagnosed with Lewy Body Dementia. Although LBD (with its severe debilitation of the brain and symptoms of visual hallucinations, sleep behaviour issues, and Parkinson's type body movement problems) has no known cure, through faithful prayer and making major changes in his diet and lifestyle, Skoff's condition was providentially reversed.

Moreover, Brother Cheisusun (2016), a member of Taiwan Manmin Church, chronologically details step-by-step how his father had been diagnosed with dementia by a medical clinic, but then after a series of prayer events and fastings (familial, congregational, and pastoral—praying in both Taiwan and Korea), his father was fully restored and subsequently given a clean bill of mental health by the same clinic where he had originally been diagnosed. This healing account even features clear comparative document screenshots of the 'before' and 'after' cognitive diagnostic reports.

Could any one of these dementia cases have simply been misdiagnosed in the first place? That is certainly possible. Could any one or all of these reversal accounts be miraculous healings of dementia? They certainly could! According to Moreland (2021), one does not need "proof" (whatever that means) to know a miracle has taken place—this sets the bar too high. All one needs to show is that "it is more reasonable to believe that a miracle has happened than it is to reject that interpretation or to remain agnostic on the issue" (Moreland, 2021). The key application here is for American pastors to reverse this anti-supernaturalistic trend regarding prayer and miraculous healings, as such a reversal could open up new doors of hope for their dementia-suffering parishioners.

Euthanasia: The Most Secular "Solution"

In her interview with the Presbyterian Church of Scotland's magazine Life and Work, renowned British philosopher Mary Warnock (2008) made some highly controversial comments about what she thought should happen to people with dementia: "If you're demented, you're wasting people's lives—your family's lives—and you're wasting the resources of the National Health Service." She then suggested that people with dementia should be encouraged to take their own lives and that the state should license people to "put them down" (i.e., to euthanise them) since the real person is no longer there and what is left of them is "just a shell" (cf. Swinton, 2016). In Warnock's own grim estimation (2008), people with dementia are non-productive and are thus deemed to be non-persons. As such, they are without value or worth—they are merely a burden.

The term euthanasia refers to the direct and intentional efforts of a physician or other medical professional to "help" a dying patient die, accomplished by a doctor administering a lethal injection of drugs into the patient, hence killing them (Rae, 2018). This is a terribly evil proposal for those with dementia, as those deemed incapable of using their minds productively are then denied any inherent right to live. Why? Because they are errantly considered to be an economic burden on the state, a social and relational load on their families, and a drain on the time of lay and professional health care workers (Swinton, 2016). Norm Geisler and Peter Boccino (2001) warn that the practice of euthanasia is already being abused, and its legislation is a very high risk of over-expansion and corruption, which would result in even more personal and societal harm. Providing euthanasia for competent, terminally ill adults will eventually expand to incompetent adults; that is, voluntary euthanasia would then eventually give way to involuntary euthanasia (Geisler & Boccino, 2001).

Human life is a good and sacred gift, and such life is not to be taken intentionally (Ex. 20:13). This notion is not dependent on a person's ability to function. It is the basis for the insistence on equal rights under the law and equal respect for human dignity (Rae, 2018). The timing and manner of a person's death belong ultimately to God (Eccl. 3:1-2). Hence, our obligation to care for the most vulnerable, which in the Bible clearly includes the weak and infirm (Ps. 41:3; 82:3; Jer. 30:17). Many patients have recovered from prolonged comas, supposedly incurable diseases, or even brain death. Given the irreversibility of euthanasia, the benefit should be given to helping people live, not helping them die (Geisler & Boccino, 2001). With good palliative care, most suffering can be comforted. As a counter to "medically assisted deaths," a palliative success has been the hospice movement, a provider of compassionate care which Christians should be eager to support.

It is here that the importance of a pastoral, congregational, familial support team for the dementia patient cannot be overstated. The more loving eyes and ears that are tangibly present (thus providing much-needed accountability) when important medical decisions are being made, the better, as hospice environments are not entirely safe spaces with regard to malpractice and even malicious intent by medical staff. The church's 'care team' can therefore be of great protective service to the beloved patient, making sure that they receive proper palliative care.

Palliative Embrace and Resurrection Hope

While death is generally a very fearful thing, for the Christian, Roxburgh (2000) stresses, the experience of death leads to an expectation of the resurrection (1 Cor. 15:55; 1 Pet. 1:3). Paul feared the idea of being

"naked" as a result of death (2 Cor. 5:3), and he longed to be clothed with a resurrection body (Phil. 3:21). The importance of a belief in the resurrection of the (*imago Dei-bearing*) body as the final hope of the Christian will affect the way in which we care for the physical bodies of those who are diminishing as a result of dementia. Caregivers will be concerned with the patient's physical appearance that they continue to dress well (in fresh, clean clothes which are frequently changed); further, that they receive dental treatment, are visited by the hairdresser, and are treated with the same dignity and respect that we show to ourselves (Roxburgh, 2000). Accordingly, for the pastor, a ministry of intentional embrace to the dementia-diagnosed can provide the attending spiritual presence that makes all the difference in their life. A spiritual palliation that is often lacking, but one that is an ever-so-necessary aspect of pastoral ministry.

5.0 CONCLUSION AND RECOMMENDATIONS

Conclusion: Through interdisciplinary literary analysis and the subsequent synthesis thereof, this study has presented biblically supported (and clinically proven) tools and methods for effectively ministering to parishioners and loved ones with dementia. While this genre of ministry is certainly one of the most challenging, by employing the strategies presented, pastors and close family members can be bolder in facing the challenges that so often prevail against proper care for dementia sufferers.

Recommendations: While biblical foundations for Christian counselling of any kind should always be the bedrock of foundation, integrating clinically proven approaches to non-verbal communications and soul-aimed connections can serve as beneficial handmaidens to the solid counselling perspectives that are readily accessible throughout the Holy Scriptures. Specifically, it would bode well for even the most stringent Nouthetic and Biblical Counsellors to consider integrating the clinically successful research findings of John Swinton, a profound Presbyterian scholar whose research would be of much benefit to any Southern Baptist minister.

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