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# Forgetful but Not Forgotten: Parish Pastoral Care of Dementia Sufferers

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During May of 2005, I participated in a field education practicum in parish ministry in a rural parish community. My supervisor was the parish pastoral associate. Part of her ministry includes pastoral care of the sick and elderly. She regularly takes Holy Communion to homebound parishioners, as well as those residing in assisted living and care centers. In my first week of practicum, I accompanied my supervisor in visiting a few of the homebound parishioners, the three care centers, and the two assisted living centers in the community. I went unaccompanied the second week. One of my first solo care center visits included leading a Communion service for a small group of residents able to come to the activity room, going to the rooms of residents unable to attend the group service, and going to the Alzheimer's unit to visit three other residents.

The group service went well. I was grateful to see two residents I had visited the previous week with my supervisor. Next I went to the rooms of two other residents physically unable to come to the service. I enjoyed the opportunity to visit and get acquainted with them. Both women were very alert and eager to chat. My last stop was the Alzheimer's unit. I felt a little uneasy as I walked down the corridor to the unit. I was not quite sure where to go, so I asked for help from a staff person I met in the hall. She took me to the door of the unit. I was accustomed to the concept of a unit for residents suffering from dementia because my father had lived in one in northwest Iowa for four years before his death. A key difference now was that I was entering the unit for the first time as a minister and not as a family member. I was nervous because I was not sure how to minister to persons suffering from dementia. I did not know exactly what I would do if they were not aware enough to receive Communion.

As I entered the unit I noticed the keypad just inside the door. I knew I would need assistance when I was ready to leave because the doors automatically locked to prevent residents from wandering and being injured. As I walked down the hall of the unit, I came to a nurse's desk located in what appeared to be the activity and dining center. I identified myself as being from the local Catholic Church and that I had brought Communion for three resident parishioners. The nurse directed me to another nurse nearby working with residents sitting in a circle. Two of the women I needed to see were seated in the circle. I was told that the third woman was in her room because she was not feeling well but that I could certainly visit her. The nurse took me to the two women. I introduced myself and asked them if they would like to receive Communion. Thankfully they said they did, so the nurse took us to a nearby table. I used the Rite for Communion in a Hospital or Institution. They participated and prayed with me when appropriate. After I concluded the prayers, I gave the two women artwork created by their first- and second-grade buddies from the parish Catholic school. They were delighted and read aloud the notes written by each student on the back of the artwork. Since they were occupied, it seemed like a good time to excuse myself and to find the room of the other woman.

The nurse directed me to the room of Marian. Marian's room was one of the first two-occupant bedrooms inside the door of the unit. Her bed was closest to the window, so I had to walk through another resident's area to see Marian. The curtain between the beds was pulled. I could not see Marian until I walked past the curtain. Her roommate was not in the room at the time, and the room was darkened except for the light from the open door and the small amount of light coming from the shade-drawn window. When I reached the curtain I could see that Marian was in bed and her eyes were closed. I spoke her name softly, and she opened her eyes rather startled. I introduced myself and asked her how she was feeling. Marian said that she was not having a very good day and that her arthritis was bothering her. I asked her if she wished to receive Communion. She said she did. I asked her if she wanted me to help her sit up, and I turned on a small lamp by her bed so I could read the prayers of the rite. With more light in the room, I could see the bruised right side of her face. I surmised that Marian had fallen recently. The fall would also explain her complaints of feeling stiff and sore. I helped her sit up, and I prayed with her. When I gave her Communion she struggled a little chewing and swallowing the host, so I offered her some water. I read the concluding prayers, gave her

the student artwork, and helped her back into bed. At that point I did not know what else to say or do. She was not talkative, and I felt at a loss for words. She seemed fairly lucid, but I knew from experience with my father that the lucidity could come and go quickly. I told her I hoped she felt better soon, and I excused myself. I walked back to the nurse's desk and asked for help to leave the unit. As I walked out the door of the unit I felt a wave of relief that I was leaving, but I also felt a nagging sense that something was lacking in my interaction with these three women.

*Personal and Spiritual Maturity*

As I have reflected on my experience of last summer, I have considered the impact my personal and spiritual maturity had on this pastoral setting. In general, I felt comfortable visiting with the elderly when they could communicate verbally, but my experiences of my father's dementia were both a benefit and a detriment. I knew from personal experience the need for and the operation of an Alzheimer's unit, and I felt relatively comfortable walking into the unit. I had an idea of what to expect from the perspective of someone visiting. But I was also concerned, knowing that a resident suffering from Alzheimer's disease or another condition that causes dementia could exhibit behavior anywhere from pleasant and lucid to agitated or completely unresponsive. I knew from experience with my father that a person suffering from dementia could be calm one moment and very upset the next moment. My anxiety level was heightened wondering how the three residents of the Alzheimer's unit would respond to me.

As I remembered my father's experience of living in an Alzheimer's unit I was saddened to think that he did not have access to more pastoral care from his parish. Ecumenical worship services were offered at the care center on a weekly basis. A non-ordained pastoral minister on staff at the care center did offer other forms of individual or small group pastoral care services at the facility. The local parish pastor came once a week to celebrate Mass with the Catholic residents who wished to attend. Catholic residents also received the sacrament of anointing of the sick twice a year. During my father's last two years in the care center, he was not considered alert enough to attend the Mass. To my knowledge Communion and anointing were the only forms of pastoral care offered to my father in his years of residency in this care center. Until my experience with these women, I never questioned whether there were other Catholic pastoral care services available to my father. I hate the thought of him having been isolated from the parish community and pastoral care in the same way that these three women are.

I felt helpless being in the presence of these three vulnerable women and with my attempts to minister to them. They became a mirror reflecting my own fear of isolation. I did not know how to respond to them in their need, but I realized that these women deserved competent, compassionate pastoral care from the parish. I did not know what this care should include, but I knew that as a pastoral minister I should have something more to offer them. Concern for the vulnerable is one of the foundational themes of Catholic social teaching.[1] Respect for life and human dignity and concern for the poor and vulnerable are foundational to parish pastoral care of the elderly, especially those suffering from dementia. Moving from this church teaching to actual practices is a major challenge. I was not prepared spiritually to meet the pastoral care needs of these women. I did not even have a sense of what their needs were. This realization moved me to reflect on my religious congregation's history of care for the elderly and vulnerable.

Nano Nagle, the Irish foundress of my religious congregation, the Sisters of the Presentation of the Blessed Virgin Mary, lived during penal times in eighteenth-century Ireland. During the day she risked imprisonment and death by teaching Irish children, and in the evening by lantern light she visited and cared for the elderly and sick in Cork City. Her concern for the poor and vulnerable sparked into flame the ministry of a small group of women that grew over time and spread throughout the world. The history of Nano Nagle's desire and efforts to minister to the elderly has recently inspired me to view the pastoral care of people suffering from dementia as an aspect of my religious vocation to vowed membership in her community and to my own pastoral ministry to the poor and vulnerable. Nano discerned the needs present in her situation and generously used her gifts in service to the poor. In my field education experience I discerned a need, but I did not yet know how to use my gifts to address the pastoral care needs of the women in the Alzheimer's unit.

[1] Catholic Social Teaching; available from http://www.mncc.org/Catholic%20%Teaching.htm/; internet (accessed February 4, 2006).

Part of what was missing was prayer. I thought I knew how to pray with these women because I knew the proper Communion rites for the sick, but I needed to be able to do more to reach them in their personal and spiritual isolation. Bringing Eucharist to them was one good way to reunite them spiritually with the parish faith community, but I also felt the need and desire to do more. During my visit with them I could have been more conscious about praying for and with them as I visited them. In doing so I may have been more open to the Spirit's guidance and may have been better able to be more present to these women and less conscious of my discomfort with the situation.

*Lay Ecclesial Ministry Identity*

I have experienced my religious vocation as a call from God to ministry in the church, a call rooted in my baptism. I had no difficulty considering my former position as a Catholic elementary school teacher as ministry within the church. My summer field education practicum was my first concrete experience of offering parish pastoral ministry. I did not have anywhere near the same amount of training and experience in pastoral ministry. Since this type of ministry was a new venture for me, I was just beginning to consider myself as called by God to pastoral ministry. Due to my lack of experience I did not feel like a minister. At the time of this pastoral visit, the only physical proof I had was a plastic name tag identifying me as a staff member of the parish. My experience of ministry to these women moved me to consider more deeply my vocation as pastoral minister and made me aware of my need for this call to be confirmed by the parish community I represented.

Before my arrival in the parish, my supervisor had prepared a written introduction for the parish bulletin to make parishioners aware of my presence and work in the parish. Each week I wrote a general summary of my ministry experiences for the bulletin. The pastor also introduced me at all of the weekend Masses my first weekend in the parish. I felt an attachment to the parish as well as a sense that I had been temporarily commissioned by the pastor to do this ministry. The parish community could recognize me as a pastoral minister through these means.

*Catholic Theology*

Scripturally, ministry to the vulnerable and in particular those suffering from dementia could be grounded on several passages, but one particular passage stands out. In Luke 5:12-16, a man suffering from a serious skin disease approaches Jesus seeking healing from his suffering. Jesus willingly listens to the needs of this man and heals him of the skin disease. In New Testament times people suffering from skin diseases were labeled as lepers and were ostracized to the point of being required to live apart from the community so as to avoid infecting others. People suffering from these skin diseases also were prohibited from participating in public worship. Jesus breaks through these cultural and societal barriers and heals the man by his listening, his words, and his touch.[2] Jesus' healing ministry brings the man back into the community. Once again the man is recognized and included in the worshiping community.

This gospel story of Jesus' healing offers a poignant image for the pastoral care of people suffering from dementia. Whether they are residing in care centers or living at home, dementia sufferers, like lepers, become increasingly isolated from the parish community. As they sink further into memory loss, interaction with family, friends, and particularly the parish community become more difficult. At some point the individual is no longer able to attend the parish Sunday eucharistic celebration. Memory loss and decreased ability to communicate make it difficult for family and friends to spend time with and talk to the person. Like the leper, the dementia sufferer gradually becomes out of sight and out of the mind of the parish community.

When the leper approaches Jesus and asks for help Jesus listens and responds with comforting words and human touch. These same gestures can become important aspects of ministry to people suffering from dementia. Parish pastoral care for these individuals needs to include the desire to listen to the person being visited and the desire to meet the person's needs to the best of the pastoral caregiver's abilities. Comforting words will include conversation as well as words of prayer with and for the dementia sufferer. In the middle to later stages of dementia, conversation can range from very difficult to impossible, but it is important to recognize the dignity of the individual with kind words and physical presence. Words of prayer spoken silently as well as aloud are always appropriate and necessary. Spontaneous prayer for the individual and her or his family

[2] Robert J. Karris, ed., *The Collegeville Bible Commentary: New Testament* (Collegeville, MN: Liturgical Press, 1992), 947.

are a source of comfort and strength. Human touch is another key component of this pastoral care. A gentle touch of the hand or shoulder can often communicate more to the dementia sufferer than the spoken word.

In the gospel story Jesus heals the man of his skin disease. He is relieved of his physical and spiritual infirmity. Regretfully, there is no cure for the mental or physical diminishment of dementia, but ensuring good pastoral care can help to make the parish community more present to the dementia sufferer as well as make the dementia sufferer more present to the parish community. 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.

Another source of the Catholic Church's care for and ministry to the elderly is found in Blessings of Age: A Pastoral Message on Growing Older Within the Faith Community. This document published by the Unites States Conference of Catholic Bishops addresses all age groups of the faith community and expresses the great dignity of and the importance of respect for the elderly. In this regard the document states:

> We are all growing older, not just as individuals but as members of a faith community. The spiritual growth of the aging person is affected by the community and affects the community. Aging demands the attention of the entire Church. How the faith community relates to older members—recognizing their presence, encouraging their contributions, responding to their needs, and providing appropriate opportunities for spiritual growth—is a sign of the community's spiritual health and maturity.[3]

The bishops' document wisely notes that recognizing and responding to the needs of the older members of the faith community are extremely important, as well as an indication of the spiritual health of the entire community. This document encourages the faith community to recognize the presence of the elderly, respond to their needs, and provide opportunities for their spiritual growth. Even though it is difficult, good parish pastoral care of people suffering from dementia, one of the groups of elderly needing care, can help to achieve these goals.

Pope John Paul II provides another ethical source for ministry to aging parishioners in his Letter to the Elderly written in 1999. He recognizes through his own experiences of age and failing health the experiences of other aging members of the church. John Paul II notes the witness of elderly people suffering with patient acceptance.[4] Their witness is a powerful example for the rest of the faith community and deserves to be recognized and valued. Their suffering is redemptive and can be united with the suffering, death, and resurrection of Jesus. Jesus does not escape his suffering—neither do dementia sufferers. They will bear this cross to death. They should not be abandoned. These sources state clearly the need for the parish community to take responsibility for the spiritual care of the elderly.

*Pastoral Praxis*

My coursework over the last year had given me a good knowledge base for taking Communion to the sick, as well as visiting with people. Last spring, in Pastoral Liturgy II, we studied the various rites for taking Communion to the sick and homebound. After taking the course and receiving instruction and modeling from my supervisor regarding the use of the rites, I knew I could use the appropriate rites at the appropriate times. During my fall semester I had also taken a course in pastoral care that focused more on the skills of nondirective pastoral counseling and specifically reflective listening. The listening required for pastoral care of dementia sufferers is different from that needed in other forms of pastoral care. In the earlier stages of dementia the individual would likely still be able to talk, but in the later stages the dementia sufferer loses the ability to communicate verbally. The listening needed for this type of pastoral care may range from listening to actual speech to listening in the silent presence of one no longer able to speak. Although I had a good introduction into the area of pastoral care of the sick, I was not prepared for using my skills to minister to persons suffering from dementia. The topic of pastoral care of persons suffering from dementia was not addressed specifically in my pastoral coursework.

A general definition of dementia is needed before moving further into the discussion of pastoral

[3] United States Conference of Catholic Bishops, Blessings of Age: A Pastoral Message on Growing Older Within the Faith Community (Washington, DC: United States Catholic Conference, 1999), available at http://www.usccb.org/laity/blessings/English.shtml/; internet (accessed February 10, 2006).

[4] Pope John Paul II, Letter of His Holiness Pope John Paul II to the Elderly (Libreria Editrice Vaticana, 1999), no. 13; available at http://www.vatican.va/; internet (accessed February 10, 2006).

care of persons suffering from dementia. Nancy L. Mace and Peter V. Rabins, authors of a family guide to care for dementia sufferers, offer this salient definition:

> Dementia is the medical term for a group of symptoms. It indicates a decline in several areas of intellectual ability sufficiently severe to interfere with daily functioning in a person who is awake and alert. . . . This decline in intellectual functioning means a loss of several kinds of mental processes, which may include mathematical ability, vocabulary, abstract thinking, judgment, speaking, or physical coordination. It may include changes in personality.[5]

Dementia is the symptom or effect of a number of possible diseases or causes. Exploring all of the known diseases or causes of dementia is beyond the scope of this case study. Here I will address the two most common causes of dementia in adults. It is important to note that some of the less common causes of dementia can be reversed with proper medical diagnosis and treatment. The two most common are irreversible,[6] but at times the progression of dementia may be slowed with proper medical care.

Alzheimer's disease is the most common cause of dementia. The late onset form of this disease commonly affects individuals sixty-five or older. Younger people may develop the disease, but this early-onset form is less common. Scientists believe genetic as well as environmental factors may increase the likelihood of someone developing Alzheimer's disease.[7] The disease progresses through the destruction of neurons; these nerve cells are a basic element of the structure of the brain.[8] Gradually the loss of neurons progresses throughout the brain, causing increased loss of memory, intellectual abilities, and eventually physical abilities.[9] A person suffering from Alzheimer's disease may survive anywhere from two to twenty years after the first signs of the disease become apparent.[10]

Some physicians categorize the progression of Alzheimer's disease, the most common cause, into three stages. The first stage is described as mild and may include some short-term memory problems, disorientation, and sudden mood changes.[11] The second stage of moderate Alzheimer's disease includes more noticeable changes in memory loss and behavior.[12] The severe stage is characterized by the inability to think and reason. An individual at this final stage needs help with all aspects of personal care. He or she is susceptible to other illnesses that may cause death in the person already weakened by Alzheimer's disease.[13]

Multi-infarct or vascular dementia is the second most common cause of dementia. It causes "repeated strokes that destroy small areas of the brain."[14] The continuation of the strokes will eventually lead to dementia symptoms. These symptoms can vary according to the areas of the brain affected. If the cause of the strokes is diagnosed and treated, further damage to the brain may be prevented. Someone suffering from multi-infarct dementia often experiences the progression of the disease in a step-like manner.[15] Knowledge of these common diseases and their progressions can assist pastoral caregivers in offering appropriate and meaningful spiritual care to dementia sufferers.

Knowledge of the staged progression of the most common causes of dementia offers a framework for providing appropriate parish pastoral care. Ministry to someone experiencing the mild stage of Alzheimer's disease requires a sensitivity to and understanding of the memory problems and disorientation the person may be experiencing. One at this stage would likely be able to talk about her or his diagnosis and the accompanying emotions related to grief and acceptance. She or he is probably still attending Mass, and a spouse or family member is caring for her or him at home. Often people are not diagnosed until the moderate stage. Ministry to someone at the moderate stage would require more flexibility in being present to the person. At times she or he may be quite alert and able to talk, and at other times she or he may be disoriented and agitated. She or he may or may not be in a care facility. Ministering to someone at the severe stage requires the most experience and comfort with sitting in prayer with

[5] Nancy L. Mace and Peter V. Rabins, *The 36-Hour Day: A Family Guide to Caring for Persons with Alzheimer Disease, Related Dementing Illnesses, and Memory Loss in Later Life* (New York: Warner Books, 1999), 410–11.
[6] Ibid., 8.
[7] Ronald Peterson, ed., *Mayo Clinic On Alzheimer's Disease: Practical Answers On Memory Loss, Aging, Research, Treatment, and Caregiving* (New York: Mayo Clinic Health Information, 2002), 41–42.
[8] Ibid., 27.
[9] Ibid., 29.
[10] Ibid., 27.
[11] Ibid., 32–33.
[12] Ibid., 35.
[13] Ibid., 36–37.
[14] Mace and Rabins, *The 36-Hour Day*, 415.
[15] Ibid., 415–16.

the person. Both silent and vocalized spontaneous prayers for and with the individual are needed. One at this stage is most likely in a care facility and is experiencing the most isolation.

Through my experience, reading, and reflection I have learned that isolation is a key issue for dementia sufferers living in care centers as well as for those still living at home. The local parish community can easily forget about or be unaware of fellow parishioners residing in care centers or at home and unable to go out any longer. This isolation prevents parishioners from being physically and emotionally present to these individuals by visiting them, remembering them, and supporting them in prayer. Often people stop visiting dementia sufferers when they no longer recognize the visitor. If the parish community is unaware of the unmet pastoral care needs of the dementia sufferers, they cannot help to meet these needs. Their geographical isolation contributes to their spiritual isolation from the community.

I believe these forms of isolation contribute to three main areas of need for dementia sufferers. The first area of need is a pastoral presence to address the problem of physical isolation, someone from the parish community who regularly visits the person at home or in the care center. The pastoral caregiver needs a basic knowledge of the common diseases that cause dementia as well as the progression of dementia. This knowledge will help the pastoral minister to be more sensitive to the needs of the person suffering from dementia and will help the minister to feel more at ease visiting.

A second area of need for those suffering from dementia is the spiritual support of prayer to address the problem of spiritual isolation. The pastoral caregiver needs to pray before, during, and after the visit. Prayer may take whatever form is most helpful to the dementia sufferer and aids the minister in being attentive. It may be silent prayer, vocal spontaneous prayer, or traditional memorized prayer. Prayerful remembrance at parish eucharistic celebrations is another aspect of prayerful support of the larger parish community.

The third area of need to be met is that of ecclesial isolation, isolation from the sacraments of the church. People suffering from dementia deserve to have access to the sacraments most helpful to them. Reception of the Eucharist may be very important to one who has received this sacrament weekly or more frequently throughout life. The sacraments of reconciliation and anointing of the sick can bring a sense of healing and peace to the dementia sufferer. These sacraments can be very consoling to one in the earlier stages of dementia.

The fourth area of need comes from the isolation from self that one experiences gradually through the stages of dementia. The dementia sufferer progressively forgets who she or he is. Parish pastoral care can assist the dementia sufferer in being able to retain her or his self-identity longer. Once the person can no longer remember, the pastoral caregiver and faith community remember for the person and keep the memory of the person alive in the faith community.

Family caregivers are another group needing and deserving good parish pastoral care, but I have chosen to limit my focus to the pastoral care of people experiencing dementia.

*Professional Practice*

I now believe that local parish communities have a responsibility to make efforts to better meet these four areas of need of the elderly and in particular those suffering from dementia. First, the parish needs to be aware of parishioners experiencing dementia and their caregivers. A sensitive way of doing this is to regularly include general prayers of intercession for the elderly members of the parish in the prayer of the faithful at the parish eucharistic liturgies. Second, all of the parish committees need to consider how their individual committees might be of service to the elderly members of the parish. It is not just one committee's responsibility to minister to their needs. For example, the liturgy committee can minister to this particular group by making sure there are trained and commissioned eucharistic ministers regularly taking Communion to them. The social concerns committee might be able assist by finding volunteers who could help with transportation difficulties of family caregivers or respite care. Third, the parish staff needs to know how to contact local agencies that may offer aging services in the event that a parishioner comes seeking help or to be able to suggest these services in a pastorally sensitive manner. It would be helpful to have a duplicated list of resources and/or organizations, their addresses, phone contact numbers, and web site addresses available for individuals seeking this type of assistance. Some examples of these organizations are the Administration on Aging (AOA), the Alzheimer's Association, Alzheimer's Disease Education and Referral Center (ADEAR), and local area agencies on aging.[16]

[16] Peterson, *Mayo Clinic On Alzheimer's Disease*, 199–200.

These suggestions are all relatively easy to accomplish, but they lead to a more challenging priority and task. Parishioners suffering from dementia need and deserve good personalized pastoral care. This challenge is a clear call to acknowledge the human dignity and worth of this easily isolated parish population.

One possible way to help meet the pastoral needs of dementia sufferers would be to seek the help of interested parishioners who could be trained to visit parishioners suffering from dementia living in local care centers as well as those living at home with family caregivers. They would be assigned to visit particular individuals on an ongoing basis to facilitate developing significant relationships. Once parishioners are trained they would go with a parish staff member for the first four visits, allowing the staff member to model good pastoral care and mentor the parish visitor. Continued individual supervision by the staff member would facilitate growth in each visitor's pastoral skills and also offer the visitors the opportunity to process their experiences of offering pastoral care to others. There are many helpful areas and techniques in which they could be trained, but I will focus on three areas and some corresponding techniques.

The first area of training would include general education about the staged progression of the most common causes of dementia and the engagement of religious memory in people suffering from dementia. Parish pastoral care of dementia sufferers would most often be for those in the moderate or severe stage of dementia, so the training would focus on these stages. Typically, people are in the moderate stage by the time they are diagnosed.

Author Jolene Brackey describes practical ideas for dementia caregivers that can easily be adapted for use by parish pastoral caregivers. Many of her suggestions would be helpful in visiting with someone in the moderate stage who is still able to speak. In her book Brackey urges the caregiver to capitalize on the dementia sufferer's long-term memory to find a memory that gives the person a moment of happiness or joy.[17] People suffering from dementia lose access to short-term memory first, and generally communication can be facilitated more easily through the use of long-term memory. The treasured memories of joy may be related to childhood, family, hobbies, or a former work profession. They are moments because the dementia sufferer at this stage only knows the present moment. Once a favorite story or topic is discovered, it is likely to be repeated over and over. The caregiver can use this story to trigger the memory and joyful moments during future visits.[18]

Trained parishioners offering pastoral care can make use of this knowledge to creatively engage long-term religious memory. One technique to do so is through the use of a Catholic reminiscence packet. It can include all or a combination of the following articles: a crucifix, a Bible, a rosary, a booklet of traditional prayers, prayer cards of individual prayers, small religious statues, a scapular, or a Sacred Heart badge.[19] The packet of materials could be taken by the person offering pastoral care to the dementia sufferer and allow her or him to look at and talk about the contents of the packet. Seeing these familiar religious articles can stimulate the religious memory and imagination of the one being visited. A pastoral caregiver should keep a list of the memory triggers of the dementia sufferer. These can be used during future visits to bring joy to the one being visited.

At the severe stage there will be fewer moments of recognition. The list of memory triggers can still be used. The dementia sufferer may not be able to talk about the memory any longer, but it still may cause some form of recognition and an experience of joy. The person may still be able to talk, but the caregiver might not be able to understand. The caregiver can still patiently listen and affirm the dignity of the person struggling to communicate.[20]

The second area of training is learning the importance of and techniques for being physically present to the person suffering from dementia. Brackey notes that being silent with the person can still bring great comfort and joy to the dementia sufferer.[21] The challenge for the pastoral visitor is to learn to be comfortable with sitting in silence and prayer. The pastoral visit does not need to be filled with continual conversation.

Touch is an important aspect of physical presence and a technique of ministry to dementia sufferers at all stages. A gentle touch of the hand, arm, or

[17] Jolene Brackey, *Creating Moments of Joy for the Person with Alzheimer's or Dementia* (West Lafayette, IN: Purdue University Press, 2003), 13.

[18] Ibid., 16.

[19] David P. Wentroble, "Pastoral Care of Problematic Alzheimer's Disease and Dementia Affected Residents in a Long-Term Care Setting," *Journal of Health Care Chaplaincy*, 8, no. 1/2 (1999): 70.

[20] Brackey, *Creating Moments of Joy*, 81.

[21] Ibid., 227.

shoulder can make the person aware of God's caring presence through the minister. Brackey notes:

> Touch can reach through the fog, confusion, and fear of dementia. Reassuring touch grounds those who are spatially disoriented, brings people back to their bodies, and increases their awareness in present time and space. One touch can affirm that they are not alone and they are valued by the person who is beside them.[22]

Jesus was not afraid to touch the man with the skin disease. This kind of touch can be a way for the minister or pastoral caregiver to communicate the compassionate, healing ministry of Jesus. People suffering from dementia deserve pastoral visits even if they are unable to respond or seem unaware of the presence of others. Knowing their loved one is receiving this type of care can provide a great consolation to the caregiver and other family members.

The third area of pastoral care training would include providing helpful listening opportunities for the person suffering from dementia. The use of music can be comforting and helpful for dementia sufferers, but music can be especially helpful for reaching someone in either the moderate or severe stages of dementia. Traditional religious hymns can be used to connect with someone struggling to remember and sometimes even speak.[23] Simply singing a favorite hymn can offer a few moments of peace and joy to one who struggles to remember. Praying the traditional Catholic prayers or reading familiar Scripture passages can also be comforting experiences of listening. If the person has a devotion to praying the rosary, she or he might appreciate listening to someone pray this prayer form even if she or he is no longer able to speak the prayers aloud.

Reading Scripture and offering Communion during a pastoral visit are another aspect of providing opportunities for listening. Training in the Catholic rites for pastoral care of the elderly and sick would be required of the parish visitors, so even when people suffering from dementia are no longer able to speak, they are still given the opportunity to listen to the Word and receive Communion as they are able. Thus they are included in the parish eucharistic celebration.

Pastoral care of persons suffering from dementia is an important but often unrecognized and unmet need in local parish communities. Pastors and parish staff members have the responsibility of providing spiritual care and discovering new ways to offer this care with the help of the parish faith community. From my experience of my father's lack of pastoral care and my experience of trying to minister to the three women in the Alzheimer's unit, I have learned and believe very strongly that people suffering from all stages of dementia still deserve good parish pastoral care. They deserve to have the parish community listen and respond to their needs. They deserve to have the spiritual and physical presence of the parish community touch them. Although they become forgetful, they do not deserve to be forgotten by the parish community.

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[22] Ibid., 101.

[23] Wentroble, "Pastoral Care," 65.