DO THIS IN REMEMBERANCE FOR THOSE WHO DO NOT REMEMBER: A STUDY OF THE DISTRIBUTION OF THE LORD'S SUPPER TO LUTHERANS WITH DEMENTIA

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CONTENTS

CONTENTS II

ABSTRACT III

INTRODUCTION 1

LITERATURE REVIEW 4

Modern Dementia Care Literature 4

The Scriptures 9

Reformation-Era Literature 11

Synodical Conference-Era Literature 13

Modern Lutheran Literature 15

Goal 19

BODY/METHODOLOGY/PROCEDURE 20

What is Dementia? 20

Impairments 21

Degrees 22

Proper Reception of the Lord’s Supper 27

Christian Faith 28

Able to Examine 34

United 49

CONCLUSION 59

Recommendations 60

BIBLIOGRAPHY 62

ABSTRACT

For members of the Lutheran church, participation in the Lord's Supper is the pinnacle of fellowship between communicant, God, and fellow believers. Every time the body and blood of Christ are distributed from Lutheran altars, celebrants repeat Jesus' words "Do this in remembrance of me." But what about Lutherans who have a form of dementia that keeps them from remembering? This paper will address the question, "Are Lutherans with dementia able to properly partake in the Lord's Supper?" This study views the matter of communing Lutherans with dementia through the lens of the Person-Centered care model and encourages orthodoxy and orthopraxy in distributing the Lord's Supper based on Jesus' words of institution in the Gospels and Paul's description of examination in his Epistle to the Corinthians. After comparing the different stages of Alzheimer's disease with the qualifications for a proper reception of the Lord's Supper, this study has determined that an appropriate Person-Centered pastoral perspective when discerning whether to commune a Lutheran with dementia is that a pastor should be forced to withhold the Lord's Supper from Lutherans with dementia instead of looking for a reason to withhold the Sacrament from Lutherans with dementia.

INTRODUCTION

One Friday evening, a tired pastor sat at his desk as the last rays of daylight streamed through the window warming his aching fingers. With a sigh of relief, he typed the "Amen" to Sunday's sermon and began packing up when he heard the desk buzz with the unmistakable warning that someone needed his attention. He tentatively picked up his phone and mustered a hearty hello, silently praying that nothing had gone tragically wrong. And it hadn't. It was a beloved member, a woman in her mid-fifties, and she was asking for a favor. She said that her mom had recently moved and wouldn't be able to drive herself to church for the foreseeable future, so she wondered if the pastor would be able to visit her with a devotion and Communion. Relieved, the pastor responded, "Absolutely!" He knew this woman. She was one of those pillars in the congregation that every pastor loves to have. She had been a faithful member for more than three decades, had served in just about any way that she could: Sunday School, altar guild, refreshments for Bible Study, and had attended every service as far back as he could remember except the previous Sundays when she had spent a stint in the hospital. "Would you mind giving me her new address?" the pastor asked, grabbing a pen and a piece of paper. But that's when his heart sank. He knew the address. It was an assisted living facility nearby, and he knew the room number: Memory Care. With a grateful, "Thank you so much! Goodnight!" the daughter hung up. The pastor let out a long sigh, collapsed back into his momentarily vacated seat, and put his head in his hands. As he sat in his now dark office, hundreds of thoughts ran through his head, all complicated by one word: dementia.

How does a pastor shepherd a Lutheran with dementia (LWD)? Sin, death, and the devil make being a minister of the gospel difficult as is, so it is hard not to get discouraged when that unholy trinity employs its last weapon reserved for those closest to heaven. What makes the prospect of ministering to LWD daunting is that dementia is a seemingly gospel-less disease. Where the gospel brings certainty, dementia brings doubt. Where the gospel brings forgiveness, dementia brings despair. Where the gospel brings fellowship, dementia brings loneliness. Warren Kinghorn expressed it well in his article "I am Still with You," "The deepest evil of dementia is its ability to isolate. Dementia isolates people from their vocations and life projects, then from their communities, then from families and friends, and finally even from themselves. It isolates the future, then the present, then eventually even the past. It can even seem to isolate a person from God."[1]

When a Lutheran is faced with doubt, despair, and loneliness, the pastor knows exactly what they need: Holy Communion. The very nature of the Supper is meant to give the recipient certainty, forgiveness, and fellowship, but the very nature of dementia throws even the distribution of the Eucharist into question and can fill a faithful pastor with doubts such as, "How can I know they have faith if they cannot confess their faith?" "How do I know if they can examine themselves when they forget to put on clothes?" How do I know if they are penitent when there are times when they cannot control their actions?" "How can we be united when they do not remember who I am?"

While there can be a lot of pastoral doubt when it comes to ministering to LWD, a servant of the gospel needs to look past all the apparent challenges that come with serving a LWD and realize that they are still, first and foremost, a Lutheran. The question then remains,

1. Warren A. Kinghorn, "'I Am Still with You': Dementia and the Christian Wayfarer," *Journal of Religion, Spirituality & Aging* 28.1–2 (2016), 112.

"In what ways can a pastor bring that gospel to Lutherans who happen to have dementia?" This paper will focus primarily on the gospel given through the administration of the Lord's Supper to determine when it is appropriate to distribute the Sacrament to LWD.

The intent for this paper is twofold: First, I write because I have experience in caregiving for people with dementia (PWD). From 2014-2020 I worked part-time in an assisted living facility where my responsibilities included not only caring for, but also communicating with, PWD. Per the requirements of the job, I received dementia care training, dementia sensitivity and communication courses, and experienced dementia simulation training. For seven years, I was exposed not only to modern approaches to dementia caregiving, but also to hundreds of PWD each with their own histories, identities, and personalities. As a result, I have seen how a caregiver's uncertainty and fear in dementia caregiving can lead to neglect; not only physical, but also spiritual.

Second, I write to educate Lutheran pastors on how they can be spiritual caregivers to LWD while maintaining orthodoxy and orthopraxy. While it might be more comfortable to venture timidly into dementia care as a pastor because of the uncertain nature of the task, it is specifically in that dark, uncertain world where many of the Lutherans closest to heaven reside. The gospel the pastor has to offer is what a PWD needs.

Therefore, in this paper, I will approach the question, "When is it appropriate to administer the Lord's Supper to LWD?" through two lenses. The first lens is the Person-Centered (PC) care model which seeks to uphold the personhood and the holistic wellbeing of PWD. The second lens is the biblical teaching of the Lord's Supper found in the Scriptures and expounded in the Lutheran confessions.

LITERATURE REVIEW

Before we can address the methodology behind administering the Sacrament to LWD, we must first analyze the different areas of literature that address said issue. The difficulty with finding literature that appropriately answers the posed question is the wide range of interpretations about what is received in the Lord's Supper. How one interprets Jesus' instituting words inevitably sways the answer to the question. For instance, if all that is received in the Lord's Supper is bread and wine, then the proper distribution of the elements is a nonissue. However, if what is received is the body and blood of the Lord, then the question becomes more pertinent. Therefore, in this literature review, I will only be addressing those resources that hold to the "real presence" view of the Lord's Supper. The five areas of literature that will be addressed are perspectives from modern dementia care literature, the Scriptures, Reformation-era literature, Synodical Conference-era literature, and modern Lutheran literature.

Modern Dementia Care Literature

In the realm of dementia caregiving, there have historically been two caregiving approaches: Reality-Orientated (RO) care and Person-Centered (PC) care. These two care models will be discussed using the following real-life situation I experienced in a dementia ward: On the way to serving breakfast, I was stopped by a woman who notoriously arrived at breakfast two hours before it was served. When I inquired about what she needed, she informed me that she wanted

me to grab an apple for her from the tree in the corner. The only trouble was that there was no tree in the corner.

Reality Orientated Care

"Reality orientation (RO) was developed in the late 1950's in response to confusion and disorientation in older patients in hospitals in the United States (Taulbee & Folsom, 1966). Reality orientation uses continuous stimulation with repetitive orientation to the environment to attempt to reorient the patient."[2] The RO care model not only formed the basis for late twentieth-century dementia care but also the framework that the average populace still employs when caring for PWD. As a result of RO, phrases like "no mom" or "don't you remember, dad?" have become the ambient noise of dementia wards.

Reality-Orientated care, as the name suggests, focuses on perceivable, objective, reality. Amnesia often accompanies dementia, so the solution to this amnesia, proposed by Taulbee and Folsom, is the strategic supplementing of what the amnesiac has forgotten. Therefore, from a RO perspective, appropriate care in the apple tree example above would include informing the PWD that there was no tree in the corner and offering to obtain for her a real apple if she so desired.

This truth-centered care model, while seeming logical, natural, and beneficial for memory recall, often comes with detrimental consequences in the field of caregiving. By all outward appearances, the results of the RO care model, in the case of the apple tree, are net positive: The PWD learned that the corner of the dining room was apple tree-free and received a real apple as opposed to the fake apple she desired. However, in the field of caregiving for PWD, a caregiver

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2. Pei-Chao Lin, Mei-Hui Hsieh, and Li-Chan Lin, "Hospital Nurse Knowledge of and Approach to Dementia Care," *Journal of Nursing Research* 20.3 (2012), 198.

must put themselves in the PWD's shoes to administer the greatest level of care. From the perspective of the PWD, the apple tree is there, and all her senses are telling her that the apple tree is there. When she hears that the apple tree isn't there, she will likely have one of two reactions: Either she will be convinced that the caregiver is lying to her, or she will be convinced that she is losing her mind. If she is convinced that she is being lied to, she will become defensive. If she is convinced that she is losing her mind, she will become sullen and depressed. Either way, further care, attention, and listening are inhibited.

To further exacerbate the issue, many dementias not only affect memory recall but also internal emotion regulation.[3] This deterioration of internal emotion regulation not only occurs frequently but also appears early in the course of the disease. For that reason, the ambient hums, muttering, and "no moms" of the dementia ward are often interrupted by over-the-top laughter, great wails of sorrow, or expletive-laden fits of rage coming from people who were "perfectly normal" moments before. When added to the apple tree example, the RO reaction might not only leave the PWD defensive or sullen but might also leave them stuck in a sea of negative emotions from which they are unable to rebound back to emotional equilibrium.

3. Curt Seefeldt, *It's Alzheimer's: It's Time for Extraordinary Love* (Belle Plaine, Min: The Lutheran Home Association, 2014), 21.

Person-Centered Care

In 1997, an opposing care model was suggested by Thomas Kitwood in *Dementia Reconsidered* where his stated goal was to focus on treating "dementia patients with empathy by maintaining their dignity and abilities and emphasizing relationship and communication to understand their perspective…"[4] He saw the deficiencies in the RO model and suggested that the caregiver focus switch from prioritizing objective reality to prioritizing the PWD's perception and reaction.

> Kitwood argued that people with dementia have an enduring sense of self, comprising thoughts, feelings, preferences and personality characteristics and he maintained that attention should be given to their personhood. He defined personhood as the "standing or status that is bestowed upon one human being by others, in the context of relationships and social beings", proposing that an individual's personhood should be recognized and emphasized in interactions, providing a safe and nurturing environment in which the person is able to express himself or herself.[5]

As a result "Providing person-centered care to older people with dementia is increasingly regarded as synonymous with best quality care in Europe, Australia, and North America."[6]

Where does this new care model fit in with the apple tree example? Instead of telling the PWD that there was no apple tree in the corner and that I could bring her an apple, I responded, "Sure!" Then I walked over to the corner of the room where she said the tree was and asked, "This one?" When she shook her head, I pointed to a different place in midair and asked, "How about this one?" She nodded. I returned, handed her the fake apple, and then took her back to her table for breakfast where she could drink some real orange juice. By living in the reality of the PWD, I was able to keep her feelings positive while providing care at the same time. If I would have told her there was no apple tree, there is no telling how she would have reacted.

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4. Lin, *Hospital Nurse Knowledge,* 198.

5. Jill Manthorpe and Kritika Samsi, "Person-Centered Dementia Care: Current Perspectives," *CIA* Volume 11 (2016), 1735.

6. Lin, *Hospital Nurse Knowledge,* 198.

The PC care model is not without its flaws, however. First, there is no guarantee that living in the reality of a PWD is going to guarantee better caregiving outcomes. The PWD from the apple tree example could have resisted care even after she obtained her "apple." Second, the caregiver must be comfortable with and committed to living in the reality of a PWD, which includes controlling their verbals and non-verbals. In many cases, non-verbal actions are as powerful, or even more-so, than words. When employing PC care, a caregiver must show no sign of irritation, disdain, or belittlement. People, by nature, reflect non-verbal emotions, which means if a PWD is shown a negative emotion, they will empathetically appropriate that emotion with no mental capacity to regulate it once it becomes subjective.[7] Additionally, committing to living in a PWD's reality includes treating their fantasies as reality, which might lead to a moral dilemma for a caregiver who sees this practice as equivalent to lying. Finally, PC care is draining work that requires considerable skill if done correctly. Where the RO model includes a neutral delivery of the truth that prioritizes objective reality, the PC model revolves around the ever-changing world and perception of the PWD.

While there may be flaws to the PC care model, there are abundant positives to putting in the time to employ PC care. "Proponents claim it (PC care) reduces agitation, slows the loss of self-care abilities, enhances decision-making abilities, helps maintain social interactivity, and helps sustain personhood as dementia develops."[8] In addition to the mental benefits associated with PC care, spiritual benefits have been noted as well, "Within the last decade, in accordance

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7. "It can be frustrating dealing with someone with dementia, and do not feel you are somehow to blame. Never let it show as they will pick it up and the rapport can be lost. Grit your teeth, take a deep breath and carry on. Remember someone with a communication problem, can also get frustrated if their views are not understood or, if their speech comes out muddled." James McKillop and Carlo Petrini, "Communicating with People with Dementia," *ann Ist super sanItà 2011 | Vol. 47, no. 4*, 335.

8. Lin, *Hospital Nurse Knowledge,* 198.

with the person-centered approach, commentators have paid increasing attention to the role played by spirituality and religion in meeting the needs of People with Dementia (PWD), and thereby enhancing the lives of PWD and those of their carers."[9] As a result of these physical and spiritual benefits, I will be using the PC care model as the framework for the discussion on the Lord's Supper moving forward.

The Scriptures

Lutheran orthopraxy in the realm of dementia care is difficult to discern from the Scriptures because there are no examples of dementia in the entirety of the biblical corpus. While the explicit mention of dementia as a condition is absent, the Bible is full of passages that a PWD, their families, and their caregivers can appropriate and in which they can find encouragement.[10]

The absence of dementia in the Scriptures does, however, encourage a conversation concerning potential differences between cognitively sound and cognitively impaired believers which would have implications on the proper administration of the Lord's Supper. This conversation will be pursued in more detail in the body of this paper.

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9. Elizabeth Kennedy et al., "Christian Worship Leaders' Attitudes and Observations of People with Dementia," *Dementia* 13.5 (2014), 589.

10. Seefeldt, *It's Alzheimer's,* 5.

Person-Centered Care in Mark 2:27

While dementia as a concept may not appear in the Scriptures, a person-centered approach to rituals does. In Mark 2:23–28, the evangelist records a time when Jesus and his disciples were walking through a grainfield. As they walked, the disciples began to pick some of the heads of grain. When the Pharisees became aware of the disciples' gleaning, they confronted Jesus, because picking grain was a violation of Sabbath law according to Rabbinic tradition. In response to the Pharisee's protest, Jesus referred them to 1 Sam 21:1–6 where King David and his men ate consecrated bread which, according to the Lord's command in Lev 24:5–9, was reserved specifically for the priests. In his response, Jesus condoned both his disciples' and David's actions and summarized his defense in v. 27, "The Sabbath was made for man, not man for the Sabbath." With these words, Jesus made known that God's intent in ordaining the Sabbath was for the people's sake, not the ritual's sake. Jesus was not encouraging a violation of the Torah or the proper observance of the Sabbath with his response, instead, he was upholding them while encouraging a person-centered mindset concerning the purpose of the Sabbath.

In the same way, we can say that the Lord's Supper was made for man not man for the Lord's Supper. The intent of the Supper is to bring the benefits God assigned to it to God's people which include forgiveness, assurance, and comfort. Just as there was an improper way to observe the Sabbath, there is an improper way to administer the Lord's Supper. Just as it is improper to administer the Supper to those who lack Christian faith, who aren't penitent, and who haven't discerned the body and blood of the Lord, so too it is improper to administer the

Supper prioritizing a proper observance of the ritual to the neglect of the recipient whom God wishes to bless in the ritual.[11]

Reformation-Era Literature

In Reformation-era literature the decision about whether a LWD should be communed is unanimous: The Lord's Supper should not be administered to those who are incapable of examination. Martin Luther says in his *Large Catechism*, "So everyone who wishes to be a Christian and to go to the sacrament should know them. For we do not intend to admit to the sacrament and administer it to those who do not know what they seek or why they come."[12] Johann Gerhard echoes Luther in *A Comprehensive Explanation of Holy Baptism and the Lord's Supper* when he says, "Therefore, the following are herewith excluded… 5. The possessed, the insane, the raving mad, the halting idiots, and the like, who are unable to use their mind, for they cannot perceive the body of Christ nor examine themselves."[13]

While the Reformers' writings on the Lord's Supper are faithful witnesses to the doctrines found in the Scriptures, there are two main holes in their writings concerning the administration of the Eucharist to LWD. First, the distribution of the Lord's Supper to LWD wasn't the issue of the day. Dogmaticians, like Martin Chemnitz and Phillip Melanchthon, who wrote profusely on the Lord's Supper, didn't mention anything in their treatises on the Lord's

11. "Both pastor and congregation must most carefully guard against denying the Lord's Supper to anyone to whom Christ wants it to be given. In his day Luther had to warn not only against laxity in practice, but also against legalism and unnecessary rigor." Francis Pieper, *Christian Dogmatics Vol 3* (Saint Louis: Concordia Pub. House, 1953), 386.

12. Robert Kolb, Timothy J. Wengert, and Charles P. Arand, eds., *The Book of Concord: The Confessions of the Evangelical Lutheran Church* (Minneapolis: Fortress Press, 2000), 467.

13. Johann Gerhard et al., *A Comprehensive Explanation of Holy Baptism and the Lord's Supper (1610)* (Malone, Tex.: Repristination Press, 2000), 427; 429–430.

Supper about those excluded from the Sacrament for mental health reasons. Instead, they focused on debating the symbolic reception of the Supper proposed by Ulrich Zwingli, the spiritual reception proposed by John Calvin, and the view of transubstantiation proposed by the Roman Catholic Church. In other words, the classical Lutheran authors wrote on topics that were pertinent at the time. As a result, the issue of communing LWD wasn't discussed in detail, and those who did write about denying the Sacrament to those with cognitive impairments spoke briefly and in vague terms.

Second, Luther and his contemporaries were hindered from speaking more thoroughly about the issue because of their lack of scientific understanding. Though the term dementia dates to the 6th century AD and the concept of age-related memory decline dates to ancient Egypt, there is evidence that the term dementia devolved in the Middle Ages into being synonymous with demon possession or punishment over sin rather than a mental illness.[14] This tendency to associate mental illness with the work of Satan can be seen in Luther's writings and is exemplified in his 1530 letter to his personal friend, Jerome Weller, where he says, "Try as hard as you can to despise those thoughts which are induced by the devil. In this sort of temptation and struggle, contempt is the best and easiest method of winning over the devil."[15] Because of this association between Satan and mind-altering illnesses, PWD were thrown into the same category as "The possessed, the insane, the raving mad, the halting idiots," and were therefore viewed as incapable of examining themselves implicitly.

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14. Hyun Duk Yang et al., "History of Alzheimer's Disease," *Dement Neurocognitive Disord* 15.4 (2016), 3.

15. Martin Luther and Theodore G. Tappert, *Luther: Letters of Spiritual Counsel*, Nachdr. der Ausg. Philadelphia 1960., The Library of Christian Classics 18 (Vancouver: Regent College Publ, 2003), 84–87.

Synodical Conference-Era Literature

Synodical Conference-era literature shows that the Lutheran understanding of administering the Lord's Supper to LWD had not dramatically changed from the Reformation-era to the formation of the Synodical Conference. Among the dogmaticians from the Synodical Conference, C.F.W. Walther, Francis Pieper, and August Pieper commented on communing LWD while their contemporaries, most notably Adolf Hoenecke, were silent on this issue.

While Walther's and the Piepers' responses concerning the proper reception of the Sacrament closely resemble that of Johann Gerhard, all three modified portions of Gerhard's original statement. For example, both Walther and Francis Pieper omitted "who are unable to use their mind." Instead, they both understand that description as referring to those who are insane or in the last moments of their life.[16] August Pieper, on the other hand, followed Gerhard more closely when he said, "We certainly do refuse it to minors, the unconscious, and the feeble-minded and insane."[17]

The difficulty in discerning these theologians' understanding of Gerhard's words is found in their lack of clarifying terms. Walther and Francis Pieper, for example, include Gerhard's catch-all "and the like" at the end of their lists, which begs the same question as Gerhard's statement: "Do LWD fit under the description of "and the like?" August Pieper did not include

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16. Such are able to examine themselves. Scripture expressly declares spiritual self-examination necessary for a salutary use of the Holy Supper: "Let a man examine himself, and so let him eat of that bread and drink of that cup" (1 Cor. 11:28). Excluded therefore are children, the sleeping, the unconscious, the dying deprived of the use of their senses, the insane and possessed while not in their right mind, etc." Pieper, *Christian Dogmatics,* 383. "The category of those who cannot be admitted to the holy Supper because they cannot examine themselves includes also the sleeping, the unconscious, those who cannot deliberate because they are in the last movements [the last gasps before death], the insane, and the like." C. F. W. Walther and John M. Drickamer, *Walther's Pastorale, That Is, American Lutheran Pastoral Theology* (New Haven, Mo: Lutheran News, 1995), 147.

17. John Philipp Koehler et al., *The Wauwatosa Theology* (Milwaukee, Wis: Northwestern Pub. House, 1997), 386.

"and the like" in his list, however, he did echo Gerhard when he used the term feeble-minded in a way not referring specifically to those who were insane or in the last moments of life.

While the Synodical Conference theologians did not refer specifically to dementia, all three of their positions suggest a link between examination and proper cognition, so it would be safe to assume that Walther and the Pieper brothers, in addition to Gerhard, would consider LWD as those who are unable to properly examine themselves and are thus disqualified from receiving the Sacrament.

What Walther and Francis Pieper add to this conversation is their mutual tendency toward a more person-centered approach to administering the Sacrament. In his *Pastoral Theology,* Walther references a situation where a pastor engaged in assisted confession and records the University of Jena's response,

> In a case in which one who desired the holy Supper had become so weak in understanding and memory that he could undertake the self-examination only with the preacher's help and could only repeat what was said to him, but had shown himself to be an upright Christian when he had greater mental powers, the theological faculty at Jena advised that he be admitted [to the holy Supper].[18]

Similarly, Francis Pieper discourages pastors from "rigorous examination" and instead encourages them to distribute the Supper to those with whom he is well acquainted with a clean conscience, even if he hasn't thoroughly explored their eligibility.[19]

Walther's and Francis Pieper's person-centered emphasis did not detract from their orthopraxy. In their comments on the proper reception of the Lord's Supper, they never advocated for a less diligent observance of the Sacrament. Instead, we can see in them a

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18. Walther, *Pastoral Theology,* 147.

19. Pieper, *Christian Dogmatics,* 386.

perspective shift toward focusing on both the proper distribution of the elements and the proper distribution of the gospel comfort found in the Sacrament.

While their shift in focus is noteworthy, both Walther and the Pieper brothers suffered from the same scientific naivety as the Reformation-era writers. Their understanding of consciousness allowed them to speak about the necessity of proper cognition in the reception of the Sacrament, but it was insufficient to allow them to speak explicitly about ministering to LWD because they lacked the proper neuropsychiatric understanding that would develop years later.

Modern Lutheran Literature

In the wake of scientific progress, much modern Lutheran literature has been written on the topic of caring for PWD. While the clarity and comfort that those resources provide have proven useful for bringing the gospel to LWD, their families, and their caregivers, very little has been written concerning administering the Lord's Supper to LWD. This lack of literature suggests that modern orthodox Lutherans have not deviated from the perspectives of the past and continue to view LWD as unable to examine themselves.

While the references are scarce, there are three orthodox Lutheran voices, all from the Wisconsin Evangelical Lutheran Synod (WELS), that speak to the issue of communing LWD: the Wisconsin Lutheran Seminary (WLS) Dogmatics notes, an article from the WELS journal *Forward in Christ* entitled "Light for Our path," and an excerpt from Lyle Lange's book, *God So Loved the World*.[20]

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20. James Pope, "Light for Our path," *Forward in Christ January Vol 101 No 1* (2014), 9.

Wisconsin Lutheran Seminary Dogmatics Notes

The comment in the WLS Dogmatics notes concerning the distribution of the Lord's Supper to LWD is as follows, "Therefore certain people are normally excluded from participation in the sacramental meal… People with severe deterioration of intellectual faculties, such as memory, concentration, and judgment (e.g., insanity, Alzheimer's Disease, senile dementia), whose condition makes self-examination impossible."[21]

This section of the Dogmatics notes not only reflects both the Reformers' and the Synodical Conference's understanding of cognitive impairment-based exclusion, but it goes one step further and expresses the core issue that excludes those groups enumerated by Gerhard, Walther, and the Piepers when it mentions the individual's severe deterioration of intellectual faculties. However, unlike both the Reformers and the Synodical Conference, the WLS Dogmatics notes also reflect the developments in neuropsychiatry when they explain that those who are "unable to use their mind" are those with Alzheimer's disease or senile dementia.

While the WLS Dogmatics notes appropriately reflect the opinions of the Reformers and the Synodical Conference on this issue, their use of the terms "Alzheimer's Disease" and "senile dementia" lack specificity and do not reflect current neuropsychiatric literature.[22]

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21. John P. Meyer, WLS Dogmatics Notes, ed. John F. Brug et al., (Mequon: Wisconsin Lutheran Seminary 17 Press, 2005), Vol. 2.D.2.F.IX.1.b.2.b., 292.

22. The term senile dementia was used for many years to describe older individuals who suffered from cognitive decline, particularly memory loss. This term actually reflects a long history of not understanding dementia, its causes, or its treatment. The nineteenth century concept of "senility", meaning cognitive changes occurring after the age of 65 years and considered to be part of normal aging, flew in the face of the cognitive accomplishments of well-known septuagenarians such as Michelangelo, Rossini, and others. As such, individuals over the age of 65 were dismissed as having senile dementia, while those under the age of 65 years who suffered a cognitive decline were considered to be undergoing a premature aging process or "presenile dementia…." Ward Pedersen, "Senile Dementia," in *xPharm: The Comprehensive Pharmacology Reference* (Elsevier, 2007), Abstract.

Light for Our Path

Unlike the dogmatic statements of the Reformers, Synodical Conference, and the Seminary Dogmatics notes, "Light for Our Path" was written for the sake of practical theology rather than systematic theology. In other words, James Pope did not write to make a dogmatic statement about the Lord's Supper. Rather, his purpose in writing was to give pastoral encouragement to the layperson who wrote looking for an explanation as to why their father with Alzheimer's disease wasn't receiving communion.[23]

Even though his purpose in writing was not to make a dogmatic statement, he inevitably had to address why the questioner's father could not receive the Lord's Supper. In his response, Pope said, "In other cases, such as your (questioner) father's, waning mental capabilities may prevent Christians, periodically or continually from examining themselves or expressing the results of an examination of the heart. In those instances, pastors have to make a judgment call and withhold Communion."[24]

In his article, Pope sets two precedents: The presence of waning mental capabilities can disqualify someone from receiving the Sacrament, and the pastor is the determiner of the LWD's aptitude for examination. Both precedents reflect the historic Lutheran position on the issue, however, both of his precedents are softened by the caveat, "may prevent Christians, periodically or continually from examining themselves."[25] Pope's hypothetical situation is intentionally

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23. Pope, *Light for Our path,* 9.

24. Pope, *Light for Our path,* 9.

25. "The thing that must be maintained is that the pastor is personally and directly responsible not only to the congregation, but also to God, with regard to the persons he admits to the Lord's Supper. Therefore the pastor has both the right and the duty to suspend those whose admission to the Sacrament would be contrary to God's will and ordinance." Pieper, *Christian Dogmatics,* 389.

nebulous to neither give expectations to his readers nor shoehorn pastors into making a specific judgment call when it comes to communing LWD.

While Pope's article is useful for pastoral care, his ambiguous wording about a LWD's inability for self-examination and the expression thereof give rise to some pertinent questions: "Where is the line between able to examine and unable to examine?" "Does the confession expected in the article have to be given through language (verbal or sign)?" "How often must this confession be ratified or renewed to be valid?"

God So Loved the World

In his study of Christian doctrine, *God So Loved the World*, Lyle Lange briefly addresses the issue of communing LWD under the heading "Who may partake of the Lord's Supper." About administering the Lord's Supper to LWD, Lange writes, "People who have an illness that makes it impossible for them to be in touch with reality (senility, mental illness, Alzheimer's disease) will not be communed unless they are in touch with reality at a given time and are able to examine themselves."[26]

Not only does Lange's view of the matter parallel that of the Reformers, the Synodical Conference, and other modern Lutheran literature, but it also suffers from similar shortcomings. He argues that LWD are included under the category of those who are out of touch with reality. The issue with that description of LWD is that he never specifies what "in touch with reality" looks like. Additionally, his examples of those who are unable to examine themselves lack the

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26. "A person's examination will center on four questions. First, Do I believe that I have offended God and justly deserve his condemnation?... Second, Do I believe that God, for Christ's sake, has forgiven me all my sins?... Third, Do I believe that in the Lord's Supper, Christ gives me, with bread and wine, his body and blood for the forgiveness of my sins?... Finally, Will I, with the help of God, change my sinful life?" Lyle W. Lange, *God So Loved the World: A Study of Christian Doctrine* (Milwaukee, Wis: Northwestern Pub. House, 2005), 521–522.

specificity and sensitivity necessary for them to be useful distinctions. Following the WLS Dogmatics notes, Lange makes mention of 'senility' and 'Alzheimer's Disease' as disabilities that disqualify a person from proper preparation for the Lord's Supper. Again, the use of these terms does more harm than good for LWD because their application risks making someone, who might be cognitively capable of examination, a potential casualty of misappropriated terms.

In addition to the examples of disqualifying disabilities, Lange provides situations where he would allow LWD to commune, however, it is under the stipulation that they are "in touch with reality at the time and able to examine themselves."[27] While this condition for reception also lacks specificity, his statement not only reflects the reality that there are times when a PWD appears more lucid than others but also follows a more PC care approach to the issue than some of the other pieces of literature discussed.

Goal

With modern dementia caregiving literature, the Scriptures, Reformation-era literature, Synodical Conference literature, and modern Lutheran literature taken into consideration, my goal with this paper is to specify the terms used in the modern Lutheran literature and form a clearer view of when administering the Lord's Supper to LWD is appropriate based on the Bible's and PC care's focus on personhood and the Scripture's teaching on the proper reception of Holy Communion.

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27. Lange, *God so Loved the World,* 522.

BODY/METHODOLOGY/PROCEDURE

What is Dementia?

Contrary to popular belief, dementia is not synonymous with Alzheimer's disease (AD). Instead, dementia is an umbrella term "which derives from the Latin *de mens* and means 'from the mind.'"[28] As an umbrella term, dementia is a category rather than an illness. Included under the dementia umbrella are diseases such as AD and multiple other cortical impairing illnesses that fit the following criteria: "[The individual] shows a decline of cognitive capacity (memory, language, judgement, etc.), with some effect on day-to-day functioning; has impairments in multiple areas of cognition; has impairments in function linked to the cognitive decline that interferes with self-care, social function, or behavior; has a normal level of consciousness (absence of delirium)."[29] While it is colloquially appropriate to say that someone has dementia, it is a misnomer to impose the dementia label on a PWD without further explanation, because it lacks specificity due to the type of dementia with which the person lives. While there are a vast

28. Peter V. Rabins et al., eds., *Practical Dementia Care*, Third edition. (Oxford ; New York: Oxford University Press, 2016), 2.

29. Rabins, *Practical Dementia Care*, 3. "It can be difficult to distinguish between delirium and dementia when memory or language is so severely impaired that the patient is unable to sustain a conversation, or when perceptual dysfunction is so marked that the patient seems not to pay attention to other people or to the environment…" Rabins, *Practical Dementia Care*, 5.

number of dementias, there is one commonality between them all: dementias are treated and regulated, but never cured.[30]

Impairments

Just as the number of illnesses that fit under the dementia umbrella is vast, so too are the associated impairments. “Examples of Neuropsychiatric Disturbances in Dementia [include]: Depression, anxiety, delusions, hallucinations, suspiciousness, irritability, agitation, social withdrawal and apathy, sleep problems, eating problems, disturbances in sexuality, catastrophic reactions, uncooperativeness with care, rummaging and hoarding, wandering and pacing, aggression.”[31] What makes any form of dementia devastating is the high prevalence and morbidity of these disturbances in the population of PWD, “Approximately 98% of patients with dementia develop one or more of these [neuropsychiatric disturbances] over the course of their condition.”[32] While every form of dementia impacts cognition, language, and daily living, the question remains: “Which disturbances common to dementia impact a proper reception of the Lord’s Supper?”

30. Seefeldt, *It’s Alzheimer’s,* 20.

31. Rabins, *Practical Dementia Care*, 7.

32. Rabins, *Practical Dementia Care*, 8.

Instead of enumerating a hypothetical list of disqualifying impairments, I will use AD throughout the rest of the paper as the paradigm dementia that inhibits proper reception of the Lord's Supper. I chose AD not only because of its prevalence in society,[33] but also because the impairments common to AD, namely amnesia (loss of memory), aphasia (loss of language), and agnosia (loss of perception), have aspects that can disqualify a Lutheran from participating in the Lord's Supper.[34]

Degrees

In the same way that there are many different illnesses categorized as dementia and many disturbances associated with these illnesses, so too, even under the label of a specific dementia, there are differing stages that display different deficits depending on the severity and the progression of the disease. "Once people have functional deficits from cognitive problems, they are classified as having Alzheimer's Disease (AD) dementia. This can be further divided into 'mild,' 'moderate,' and 'severe.'"[35] The different stages and their accompanying symptoms will be discussed below supplemented by definitions from *Practical Dementia Care* and the Alzheimer's Association.

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33. "The prevalence of AD is age-dependent. In the United States, 8%-12% of persons 65 years of age or older are estimated to suffer from the disease. The prevalence increases with age. It is 8%-10% for persons 75 years of age or older, 20%-25% for persons 85 years of age or older, and 40%-50% for those older than age 90 years. The estimates are consistent across almost all racial and cultural groups." Rabins, *Practical Dementia Care*, 24. "By far the most common type of 'dementia' is Alzheimer's disease. This accounts for some 60–70% of cases, and one of the earliest symptoms of this debilitating disease is loss of short-term memory." Graham D. S. Deans, "When Mind and Memory Flee …: Hymns and Ministry to People with Dementia," *TinS* 27.1 (2020), 5.

34. Rabins, *Practical Dementia Care*, 18.

35. Rabins, *Practical Dementia Care*, 21.

Mild Alzheimer's Disease

At the mild AD stage, a diagnosis is difficult because the symptoms of mild AD are nearly identical to those of normal aging.[36] On account of the similarities between AD and senility, mild AD usually goes unnoticed by the general public and is noticed primarily by family, close friends, or doctors who are either familiar with the symptoms of AD or familiar with the patient's Instrumental Activities of Daily Living (IADLs).

> In mild AD, memory impairment predominates. In some individuals, personality changes and mild executive function impairment are also present. Impairments in instrumental activities of daily living (IADLs) such as writing checks, shopping, and meal planning and preparation are present, but impairments in activities of daily living (ADLs) – that is, dressing, bathing, toileting, transferring, and walking – are absent or minimal.[37]

In addition, the Alzheimer's Association lists the following as deficiencies common to mild AD: "…coming up with the right word or name; remembering names when introduced to new people; having difficulty performing tasks in social or work settings; forgetting material that was just read; losing or misplacing a valuable object; experiencing increased trouble with planning or organizing."[38]

The impairments common to mild AD can be best described as gaps in cognition rather than deficits. To put it crudely, if someone with mild AD has forgotten where they put their keys, for example, their brain still knows where the keys are, but it cannot complete the neurological path from long-term or short-term memory to memory recall for the PWD to utilize the desired

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36. A.F. Pettersson, E. Olsson, and L.-O. Wahlund, "Motor Function in Subjects with Mild Cognitive Impairment and Early Alzheimer's Disease," *Dement Geriatr Cogn Disord* 19.5–6 (2005), 299.

37. Rabins, *Practical Dementia Care*, 21.

38. "Stages of Alzheimer's," Alzheimer's Association, accessed December 7, 2023, https://www.alz.org/alzheimers-dementia/stages.

information. Often a prompt in the form of sensory stimuli is sufficient to fill the cognitive gap for the brain to produce the information.

A testament to the potential high functionality of a person with mild AD is the existence of different Alzheimer's working groups throughout the world such as Alzheimer Europe. One such working group was run by James McKillop, the founding member of the Scottish Dementia Working Group (SDWG), who was a PWD at the time. In an article entitled "Communicating with People with Dementia," McKillop gave communication suggestions and strategies for dementia caregivers from a PWD's point of view. In the same article, Carlo Petrini, a co-author with McKillop, described McKillop's accolades:

> James McKillop is well known for his continued and tireless campaigning to highlight the need to support people with dementia and their carers. On 6 July 2011 he has been awarded a Member of the British Empire (MBE) from the Queen in recognition of his work to promote the rights of people with dementia and to raise awareness of the disease. James McKillop has taken part in several research studies and has reported his experiences in prestigious international conferences and events.[39]

Though he had been diagnosed with a form of dementia, McKillop still retained sufficient cognitive capabilities to not only produce a coherent article worthy of an academic journal but also to give dementia care-promoting talks throughout Great Britain. Though McKillop's story is anecdotal, it nevertheless testifies to the fact that a dementia diagnosis doesn't demand a detrimental deficit in cognition.

39. McKillop, *Communicating with People with Dementia*, 333–336.

Moderate Alzheimer's Disease

"Middle-stage (moderate) Alzheimer's is typically the longest stage and can last for many years…. During the middle stage of Alzheimer's, the dementia symptoms are more pronounced. The person may confuse words, get frustrated or angry, and act in unexpected ways, such as refusing to bathe."[40] *Practical Dementia Care* describes moderate AD in this way:

> In moderate AD, patients develop significant impairments in language, the ability to perform everyday activities, and in recognition of people, places, and situations. Functioning becomes impaired to the point that IADLs such as shopping, paying bills, or cooking must be supervised. People with moderate AD rarely live independently and usually reside with family or in assisted living facilities.[41]

It is important to note that people with moderate AD are still able to complete IADLs. Additionally, the supervision described above doesn't imply that the PWD lacks the cognitive abilities to complete the tasks.

Even though moderate AD has its place in the AD hierarchy, there are varying degrees of impairment even inside this stage. In other words, everything about moderate AD is volatile. For example, people with moderate AD are impacted by negative events just like people who lack cognitive impairment, however, where an able-minded person will generally retain the ability to communicate and socialize appropriately even after a negative event, a person with moderate AD is statistically more likely to suffer complete conversational degradation should they experience the same event. It is for these reasons that the PC caregiving model has a greater impact on

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40. Alzheimer's Association, *Stages of Alzheimer's,* 3.

41. Rabins, *Practical Dementia Care*, 22.

people with moderate AD than those with mild AD because the consequences of poor communication are higher when caring for a person with moderate AD than with mild AD.[42]

Severe Alzheimer's Disease

"In severe AD, memory, communication, and praxis and recognition become markedly impaired. Impairments in basic capacities, such as walking and toileting, develop. Most people in the third stage need considerable help with basic daily activities such as bathing, dressing, and mobility."[43] While the range of symptoms that comprises severe AD varies as much as mild and moderate AD, what differentiates this stage from the others is the presence of cognitive deterioration that results in a complete breakdown of communication. As a result, a person with severe AD is prone to babbling, humming, dramatic mood spikes and drops, and severe memory loss. The extent of this memory loss can even impact the recognition of family members and spouses. As a result of these tendencies and impairments, people with severe AD need "around-the-clock assistance" to maintain wellness and safety.[44]

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42. "The temperament of a person with moderate AD isn't solely dependent on stimulations. Even the time of day can play a role in PWD's disposition. "The clinical phenomenon of disruptive behavior worsening in the late afternoon or evening among dementia patients or elderly institutionalized patients has been reported in the medical literature for more than 60 years (1). Terms used to describe this phenomenon include sundowning, sundowning syndrome, and nocturnal delirium (2). Typical research definitions of sundowning have included "delirium and agitation" within one hour of darkness (1) or "the appearance or exacerbation of behavioral disturbances associated with the afternoon and/or evening hours." David Bachman and Peter Rabins, "'Sundowning' and Other Temporally Associated Agitation States in Dementia Patients," *Annu. Rev. Med.* 57.1 (2006), 499.

43. Rabins, *Practical Dementia Care*, 22.

44. Alzheimer's Association, *Stages of Alzheimer's,* 5.

Degrees and Distribution

When deciding who should be communed, the stages of a specific dementia need to be taken into consideration. It would be improper to dogmatically assert that a pastor ought to refrain from communing anyone who has AD because that would suggest that a person with mild AD has the same capacity for Communion preparation as a person with severe AD. Additionally, the time when someone is diagnosed with AD is arbitrary.[45] If the diagnosis of AD is the line of demarcation between the admission and prohibition to the Supper, then someone with severe AD could commune without a diagnosis whereas someone diagnosed with mild AD would be rejected. Instead of fencing a LWD on the grounds of a diagnosis, the admission or prohibition of a LWD should be based on the same qualifications as any other Lutheran.

Proper Reception of the Lord's Supper

As alluded to in the literature review, the answer to the question, "When is it appropriate to administer the Lord's Supper to Lutherans with dementia?" depends on the interpretation of Jesus' words on the night he instituted Holy Communion (Mt 26:26–29; Mk 14:22–25; Lk 22:17–20; 1 Cor 11:23–25). While the records of Jesus' words on Holy Thursday make up the *sedes doctrinae* for the Lord's Supper, they are only the foundation on which the discussion of communing LWD must build. The real prompt of the question is found in 1 Cor. 11:27–29 where the Apostle Paul states, "So then, whoever eats the bread or drinks the cup of the Lord in an unworthy manner will be guilty of sinning against the body and blood of the Lord. Everyone

45. "For many patients, the diagnosis is not made until symptoms have existed for 2 or 3 years." Rabins, *Practical Dementia Care*, 24.

ought to examine themselves before they eat of the bread and drink from the cup. For those who eat and drink without discerning the body of Christ eat and drink judgment on themselves."

In a pious effort to revere Jesus' instituting words and to adhere to Paul's instructions, congregational leaders have historically taken it upon themselves to decide who is to partake of the Sacrament and who is to be prohibited to protect all potential participants from sinning against the body and blood of the Lord and from eating and drinking judgment on themselves.[46] The Lutheran Reformers and dogmaticians, therefore, have extrapolated expectations from Scripture to determine who can properly partake in the Sacrament. The expectations are as follows: have Christian faith, be able to examine yourself, and be united in confession with the officiating church. In the following section, these three qualifications will be the standard to which the three stages of AD will be compared to determine which stage(s) are capable of proper preparation and able to receive the Sacrament.

Christian Faith

Across all of Christendom, faith is perceived as a prerequisite for receiving the Lord's Supper. Concerning the relationship of faith to the Lord's Supper, Luther writes, "And because he offers and promises forgiveness of sins, it [the Lord's Supper] can be received in no other way than by faith."[47] The Formula of Concord echoes Luther when it says, "We believe, teach, and confess that there is only one kind of unworthy guest, those who do not believe. Of them it is written,

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46. For the conscientious pastor the great agonizing question in the administration of the Sacrament in our congregations, often hurriedly collected without care or discrimination (one need only think of the lodge-brothers "brothers"!), is always whether or not we may admit this one or that to the Sacrament. Pieper, *The Wauwatosa Theology,* 385.

47. Kolb, *Book of Concord*, 470.

'Those who do not believe are condemned already'" (EP VII 18). The Lutheran Church Missouri Synod (LCMS), in their 1999 report "Admission to the Lord's Supper" reflects the Confessions when it says, "The faith of one who communes worthily includes faith in Christ in a general way as well as faith in the real presence of Christ's body and blood….Faith, as that means by which a sinner receives the gift of God, takes front and center in all of the confessional teaching regarding the reception of the Eucharist in a worthy manner (that is, to one's blessing)."[48]

The necessity of faith in the reception of the Lord's Supper can also be found in its function as the Sacrament of Confirmation, "The relation of the Lord's Supper to Baptism is correctly defined by the old theologians when they call Baptism *sacramentum initiationis* and the Lord's Supper *sacramentum confirmationis*. A person must have been baptized before he may partake of the Lord's Supper."[49] The *sacramentum confirmationis* finds its practical application to the question of administering the Lord's Supper to LWD in the words of Adolf Hoenecke,

> According to Scripture, there is no such emergency case in regard to the Lord's Supper as there is in regard to Baptism. Our dogmaticians, therefore, have decided that if a sick person desires the Lord's Supper and a pastor cannot be reached, we should convince him that spiritual partaking is enough for him and that more anxiety than comfort must come from a partaking of the Lord's Supper that departs from the order of God.[50]

In other words, since there is no emergency case for administering the Lord's Supper, LWD would not intrinsically receive the Sacrament to their benefit without following proper examination.

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48. The Lutheran Church—Missouri Synod, *Admission to the Lord's Supper: Basics of Biblical and Confessional Teaching* (Saint Louis: Concordia Publishing House, 2000), 20, 32.

49. Pieper, *Christian Dogmatics,* 291–292.

50. Adolf Hoenecke, *Evangelical Lutheran Dogmatics* (Milwaukee, Wis: Northwestern Pub. House, 1999), 140–141.

While faith is a prerequisite to Holy Communion, there may be times when Lutherans with AD (particularly late stage) might seem to have lost their faith.[51] When it comes to AD and faith, there are two topics to discuss: the psychological nature of faith and the matter of reading the heart.

Psychologically and Supernaturally

The Scriptures speak of the Word's psychological function in passages such as: "faith comes from hearing the message…." (Rom 10:17), "Then he opened their minds so they could understand the Scriptures." (Lk 24:45), "For this reason, since the day we heard about you, we have not stopped praying for you. We continually ask God to fill you with the knowledge of his will through all the wisdom and understanding that the Spirit gives…" (Col 1:9). Commenting on the psychological working of God's word, Johann Hülsemann states,

> When the Word of God is understood in its original sense, when it is applied to a suitable subject [a person capable of being taught] as an instrumental cause, it exercises its divine power to enlighten the darkened minds of men with the knowledge of divine things, to turn the will from evil to good, from hatred against God to trust in him, etc., indeed, not in a physical way, by contact with the agent, as opium, rhubarb root, poison, fire, and so on work in a physical way in a suitable subject [e.g. you cannot poison a stone], but it works in a psychological way (moraliter) by enlightening the mind, by moving the will, by cleansing the emotions, etc. For the phrase "in a psychological way" here is not to be understood as opposed to a supernatural contact and influence but only as a repudiation of any concept of physical contact and influence.[52]

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51. "Dementia leads my elderly father to speak like he has lost his faith…" Pope, *Light for our path,* 9; "Sometimes people worry that a person with dementia will lose his or her faith in Jesus. After all, Alzheimer's robs a person of the ability to remember. People also observe that Alzheimer's takes away a person's ability to communicate his or her faith." Seefeldt, *It's Alzheimer's,* 14.

52. Johann Huelsemann, Praelect. in Form. Conc., sect. I, part 2, par. 2. Please note that "[a person capable of being taught]" is the original translator's decision, not the author's interpretation of the text.

Not only does the psychological working of God's Word presuppose that the hearer will remember what they heard but it also demands that the hearer understands what is being said in the first place. Therefore, the psychological nature of the Means of Grace throws their efficacy to LWD into question because of the morbidity of both amnesia and agnosia in AD.

The deterioration of the semantic range in AD is well documented and is one of the indicators that the disease is transitioning from mild to moderate severity.[53] This deterioration includes both the creation of words spoken and the processing of words heard.[54] Additionally, a PWD's deteriorated semantic range has a greater impact on broad concepts than simple concepts. For example, closed questions posed to a PWD will often see better results than open questions because the necessary semantic range required to answer the former is less than the latter.[55] As a result, the PWD's ability to not only process but also retain the spoken Word deteriorates as the disease progresses.

While the psychological aspect of the Means of Grace is impacted by the presence of amnesia and agnosia in AD, it does not mean that the Word of God has lost its efficacy. The

53. "As the disease progresses, it disrupts a person's ability to process language." Seefeldt, *It's Alzheimer's,* 20.

54. "It becomes more difficult for a person with dementia to understand what is being said to them or to respond so that others can understand them, therefore the language used, tone and volume of words spoken and also non-verbal communication become increasingly important… Kay De Vries, "Communicating with Older People with Dementia," *Nursing Older People* 25.4 (2013), 32.

55. "Ten communication strategies often mentioned in the dementia caregiving literature 1. Eliminate distractions, for example, television and radio. 2. Approach the person slowly and from the front; establish and maintain eye contact. 3. Use short, simple sentences. 4. Speak slowly. 5. Ask one question or give one instruction at a time. 6. Use 'yes' or 'no' rather than 'open-ended' questions. 7. Repeat messages using the same wording. 8. Paraphrase repeated messages. 9. Avoid interrupting the person; allow plenty of time to respond. 10. Encourage the person to 'talk around' or describe the word he or she is searching for." De Vries, *Communicating with Older People*, 33.

Word of God works both psychologically and supernaturally.[56] James Pope says it well in his article "Light for Our Path," "All this (the prohibition from receiving communion) does not mean that your father is cut off from the means that will strengthen and preserve his faith. The simple spoken Word of God can penetrate his heart."[57]

There is overwhelming anecdotal evidence concerning the supernatural ability of God's Word to reach PWD, even in late-stage AD. A few examples are listed below:

> I just had a situation a couple of weeks ago where I actually did a wedding in a hospice home with the gal and because her mom was going to die and she wanted her mom to see and her mom was not really coherent. And I reminded her, I said, remember, one of the last things to go is the sense of hearing. And that's what you see with those folks. I mean, they may not be speaking. You know, there may be, and you have probably seen it, I call it the blank stare, but they still hear the gospel. And that's what I encourage our brothers all the time. We say the Word works. You've got to trust it. And then when you do, you get to see some pretty cool things happen.[58]

"The Lord's Prayer was reported as most accessible for PWD. (Participant 6): 'There was one lady I visited, all she could say was the word 'visitor' ... except The Lord's prayer. She could say The Lord's Prayer with me, and as soon as we finished she was unable to say any other word.'"[59]

> He [PWD] was how, just as the Holy Spirit can unlock the hearts of lifeless sinners, in the same way he can unlock confused minds of His elderly people. We see this in the prayers that dementia sufferers sometimes unexpectedly say. One of our home managers thinks that the fact that a sufferer can offer up a meaningful prayer at exactly the right moment is one of the strongest proofs that God exists. Far from being a thoughtless repetition of things learned long ago these prayers are fresh and appropriate.[60]

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56. "For the word of God is alive and active. Sharper than any double-edged sword, it penetrates even to dividing soul and spirit, joints and marrow; it judges the thoughts and attitudes of the heart" (Heb 4:12).

57. Pope, *Light for our path,* 9.

58. Joel Gartner, personal interview with the author, September 7, 2023.

59. Kennedy, *Christian Worship Leaders,* 589.

60. Louise Morse, *Worshipping with Dementia: Meditations, Scriptures and Prayers for Sufferers and Carers* (Grand Rapids, Mich.: Monarch Books, 2010, 17.

Even though the Word of God works psychologically, there is not only Biblical precedent to insist that the Word is effective for a person with AD but there is also anecdotal evidence that the Word reaches those who have a thoroughly depleted semantic memory.

Reading the Heart

The objection has been raised that since a pastor cannot read the heart of a person who is incapable of confessing their faith, he should therefore abstain from distributing the Supper to them because he cannot definitively ascertain their faith.[61] The Biblical precedent for caution when trying to read someone's heart comes from 1 Sam 16:9b, "The LORD does not look at the things people look at. People look at the outward appearance, but the LORD looks at the heart," and Mt. 7:20 where Jesus points to actions and confessions as an indication of confessional stance, "Thus, by their fruit you will recognize them." Based on these two passages, generations of pastors have noted that actions and confessions are the only standards that determine authentic faith. If that position is taken to its conclusion, what can be said for those in the moderate to late stages of AD who are incapable of giving a clear confession of faith because of their agnosia?

In response to the fear that the one who cannot confess their faith does not retain faith, Curt Seefeldt reminds his readers "that it is not the ability to communicate our faith that makes

61. "For all practical purposes, the question as it relates to the Lord' Supper concerns how once can be sure to recognize the despisers of grace who announce for the Lord's Supper. Here one may not operate with what might be the attitude in the heart of the applicant in order to make a determination either way. The pastor with a sensitive conscience may not say, "Tis man I must exclude from the Sacrament because he does not go to the Lord's Supper with the proper frame of mind." And the pastor with an obliging conscience may not say, "This one I accept because it is quite possible that he comes to the Lord's Table with pure Christian intent." Both commit the error that they want to act upon an *assumed* attitude of the heart of the one who comes. They pass judgment on his heart. But surely that is exclusively God's business. We see only what lies before our eyes and can end up doing exactly the wrong thing in following our opinion *De occultis non judicate exxlesia!* [The church does not judge hidden things] …" Pieper, *The Wauwatosa Theology,* 389.

us Christians. Rather, faith is simple trust in the promises of God…Our faith remains even if we lose some knowledge of the Bible verses we memorized, the ability to memorize new ones, or the ability to be an active participant in devotions and prayers."[62] Additionally, Francis Pieper speaks to this topic when he quotes Luther on the faith of the unconscious, "The truth that the adult believer is not necessarily always conscious of his faith is thus set forth by Luther: 'tell me, is the Christian deprived of his reason when he is asleep? Certainly, then, his faith and God's grace do not leave him."[63]

While it is true that one should not distinguish faith outside of the confessions and actions of the individual, the operating assumption of this paper is that the LWD in question were not converted during delirium but were welcomed into fellowship during a more lucid time when they could make the expected confession. Therefore, based on the efficacy of God's Word and the Spirit's sustenance of faith, we can say that the Christian faith required to receive the Lord's Supper to one's benefit can be present in all three stages of AD if they were practicing Lutherans before the onset of the disease.

Able to Examine

While the LWD's Christian faith needs to be established before they can be admitted to the Lord's Table, the real hurdle between the LWD and the Altar is the ability to examine themselves appropriately (cf. 1 Cor 11:28). To set up a framework for what Paul means when he says, "examine themselves," Lutheran dogmaticians have established three criteria for

62. Seefeldt, *It's Alzheimer's,* 14–15.

63. Pieper, *Christian Dogmatics,* 449.

examination: confession of sins, discerning the body and blood of Christ in the Sacrament, and the appropriation of the Supper's blessings.

Confession of Sin

When it comes to confessing sins, LWD have the same struggle as they do with confessing their Christian faith: The deficiencies caused by AD inevitably lead a LWD's brain to a place where a coherent verbal confession is impossible.[64] However, the more pressing concern for a person with AD than the inability to verbalize their belief is their tendency to "act out" as a result of the disease.[65] The following interview conducted by Sherry Dupuis, Elaine Wiersma, and Lisa Loiselle, staff members at a long-term care facility in Ontario, Canada gives a caregiver's perspective of the moral deficiencies in people with AD.

> [Administrator] Viewed through the lens of pathology, dementia was assigned moral status. Staff members perceived that persons with dementia had lost the ability to reason and to know the difference between right and wrong: "There's just no remorse in there because there's no area in the brain that's corresponding right from wrong or good or bad". [Nurse] As such, residents with dementia did not necessarily know they were exhibiting specific behaviors.[66]

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64. "In a case in which one who desired the holy Supper had become so weak in understanding and memory that he could undertake the self-examination only with the preacher's help and could only repeat what was said to him but had shown himself to be an upright Christian when he had greater mental powers the theological faculty at Jena advised that he be admitted [to the Holy Supper]." Walther, *Pastoral Theology,* 147.

65. "Patients with AD experience a variety of noncognitive behavioral disorders that affect approximately 60% of them at any one time and 90% during the course of the illness… Agitation – Many variants but almost always accompanied by emotional distress; Aggression – Physical aggression directed toward others tends to be the most challenging problem for caregivers and long-term care facilities; Disinhibition – May make rude comments, sexual innuendo, disrobing; Irritability/lability – Short temper, flying off the handle…" Rabins, *Practical Dementia Care*, 23.

66. Sherry L. Dupuis, Elaine Wiersma, and Lisa Loiselle, "Pathologizing Behavior: Meanings of Behaviors in Dementia Care," *Journal of Aging Studies* 26.2 (2012), 165.

Considering this perceived inability to decipher right from wrong, the question pertinent to proper examination is “Can a Lutheran with AD be penitent and confess their sins?”

Before the question can be answered, two realities of “acting out” must be addressed. First, it should be noted that the caregivers interviewed above work in long-term care, which indicates that all of their residents have, at the bare minimum, moderate AD. In my time as a dementia caregiver, I observed that even though people with moderate AD “acted out” on occasion, most of the deviant behavior came from those with severe AD.

Second, in my experience, residents rarely acted out unprompted. What could have been perceived as amoral behavior wasn’t spontaneous, wanton defiance; instead, it was a reaction to negative stimuli that occurred either in the moment or earlier in the day.[67] Another caregiver from the previous interview noted a similar experience: “It's not attention for attention's sake when they act out. There is a reason, always is a reason behind it when, I feel, you're dealing with Alzheimer's or dementia there's, in their mind there's a reason behind it. It's not acting out for acting out sake you know.”[68]

Part of maintaining a PC perspective when caring for PWD is not only seeing situations through their eyes but also treating them as a person, which includes the application of God’s law. When a person with AD acts out, their actions are still sinful even though they may not know the moral implications of what they are doing. It must also be reinforced that they are still Christians, even when they act out. King David’s words in Ps 19:12 are useful here: “But who can discern their own errors? Forgive my hidden faults.” For a person with moderate to severe

67. “Individuals come to be defined by misunderstood behaviors, as the wanderer, the screamer, the hoarder, violent, non-compliant and so forth. Thus, even though actions may be appropriate and completely legitimate given the circumstances, the behaviors and consequently the individuals are labeled as abnormal and deviant because broader contexts are rarely considered (Dupuis, 2010; Dupuis et al., 2011).” Dupuis, *Pathologizing Behavior*, 163.

68. Dupuis, *Pathologizing Behavior*, 166.

AD, while every one of their faults might be a hidden fault, the fact that their cognition is impaired doesn't mean their conscience is impaired. Though it might not be perceivable, a PWD still experiences happiness, sorrow, grief, pain, and, most importantly for this conversation, remorse.

While a pastor might be concerned about a PWD's penitence when they act out as a result of their illness, it is important to remember that the presence of sin is universal. The PWD acts out sinfully and the able-minded person acts out sinfully. The reason why the actions of the PWD are identified as acting out by caregivers isn't because their sins are somehow more grievous, but that they sin in ways that are perceived as unusual and socially unacceptable by those whose methods of sinning are more refined.[69] Therefore, a confession of sins that leads to a proper reception of the Lord's Supper isn't based on the identification of the quantity or quality of sin in a person's life, but on the presence of faith. John Schaller said it well in his article "Self-Examination, according to 1 Corinthians 11:28:

> In the entire context he [Paul] doesn't speak a single word about all sorts of things that in the course of the centuries were stressed so heavily as being necessary for the preparation for the Lord's Supper. For example, Paul says nothing about the confession of sins. That he assumes this is self-evident; but he does not write: A person ought to examine himself, whether he has a proper understanding of [his] sins. One has certainly misunderstood it [inferred such a phrase] many times and on account of that has written and spoken it in books for confession and Communion, and also in the confessional address, so that each upright Christian who wanted to go to the table of the Lord came to it only with trembling and in the greatest uncertainty.[70]

69. "Interpreting behaviors through the lens of social appropriateness meant that, for certain behaviors, morality and values came into play when assigning meaning… . I think it's more difficult because it's such a moral, there's so many values attached to that and I think we're all at different places depending on what our experiences are and what our morals are and how we've been raised so I could see that as being a real difficult area." Dupuis, *Pathologizing Behavior*, 168.

70. Schaller, *The Wauwatosa Theology,* 367.

In summary, the answer to the question, "Can a Lutheran with AD be penitent and confess their sins?" rests not on the ability of the LWD to enumerate their sins and demonstrate their penitence, but on the faith that the Spirit preserves through the Means of Grace. As mentioned in the previous section, Lutherans in all three stages of AD have faith, and thus meet the preparation expectation of the confession of sins.

Discern the Body and Blood

The issue of reading the heart is revisited in the discussion about discerning the body and blood of Christ in the Eucharist. In an effort to concern themselves with actions and confessions to determine someone's faith, the Reformers insisted that any hopeful recipient of the Lord's Supper discern the body and blood verbally.[71] Their determination to prevent any improper participation can be seen in Gerhard's admission of mutes to the Lord's Supper on the condition that they sufficiently demonstrate, through signs, that they discerned the body of Christ.[72]

It is here, in these signs demanded by Gerhard, that we find a place for LWD. While there are some Lutherans with AD that are still able to communicate verbally, many in the later stages of moderate AD and severe AD have restricted or negligible semantic ranges. In this way, LWD are semantically similar to the mutes of Gerhard's day: Both lack the words necessary to express

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71. "Here again are apparent points of contention… 5. That one also finds certain insane and mindless ones who at certain times are sane and desire the holy Supper; should one refuse it to them? ANSWER: In such a situation, one should not deny them the holy Supper, provided that they can with express word give confession that they can examine themselves and distinguish (discern) Christ's body…" Gerhard, *Lord's Supper,* 431.

72. "7. That one finds some mutes, who with wonderful gestures (signs) acknowledge their repentance, faith, and devotion-yes, even the desire for the holy Supper; should one deny such? ANSWER: If they possess a sound mind and by such signs indicate that they examine themselves and distinguish (discern) the body of Christ, then one should not wantonly exclude them from the holy Supper; for the Holy Spirit can just as readily do His work on them as He can on the children in their mother's womb." Gerhard, *Lord's Supper,* 433.

their beliefs and both have to resort to an unconventional sign system to communicate.[73] The fact that Gerhard allowed mutes to commune with a sign-based recognition of the body of Christ sets the precedent for other non-verbal participants. In other words, at the heart of discernment is the communication, not the verbalization, of recognition.

Since the discernment of the body of Christ must be communicated, the next question to be addressed is, "Can people with moderate to severe AD communicate?" If you have ever spent time with a person who has moderate to severe AD, you will know that very little of what comes out of their mouth rationally communicates. For those who still possess a semantic range, their speech often consists of incoherent sentence fragments that express delusional thoughts and memories. For those who have lost word recall altogether, their babble often resembles language in tonality and meter but nothing more. Should a caregiver approach a person with moderate to severe AD as they would an able-minded person, they might be convinced that the PWD has lost the ability to communicate entirely.

From a PC care perspective, there is something fundamentally wrong with the hypothetical scenario above. Communication breakdown is rarely a result of the person with AD's ability to communicate, rather, communication breakdown is often a result of a caregiver's approach and expectations. A caregiver can't communicate effectively with a PWD if they expect the individual to communicate as the caregiver communicates. All conscious humans communicate. Therefore, to uphold the personhood of PWD, rather than asking, "Can people with moderate to severe AD communicate?" PC care asks, "How do they communicate?"

In answer, Dupuis et al. point to behaviors, rather than words, as a PWD's *lingua franca*, "For some, behaviors in the dementia context were also viewed as means of communication, as a

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73. [In Luther's day and Walther's day, the deaf could not be educated as well as they can be today.] Walther, *Pastoral Theology*, 147.

method of expression, and for some the only method they had of communicating with others. As such, when interpreted in this manner, behaviors were imbued with meaning."[74] The 2002 study entitled, "Beyond Words," agrees with the idea of behavior as communication when it says, "Some of the frail older people used nonverbal behaviour to compensate for their loss of verbal communicative abilities. Their nonverbal behaviour became the main way in which they remained part of the communicative worlds of the day centre."[75] Caregivers of PWD are extremely sensitive to the nonverbals of people with moderate to severe AD because they rely on their actions to know how to provide them appropriate care.[76]

One additional PC consideration concerning the nonverbal communication of late-stage AD is the validity and value of their communication. While it is true that words communicate more effectively than actions, a PWD's actions nevertheless have the intrinsic value of a verbal person's words. Both the verbal and nonverbal communicate that which is essential to personhood, namely emotions, desires, and feelings, in the clearest way that they can. Therefore, the absence of definite meaning, which often accompanies nonverbal communication, doesn't give the caregiver license to ignore the signals given. Instead, it obligates the listener to strive all the more to understand what the PWD is trying to communicate.

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74. Dupuis, *Pathologizing Behavior*, 166.

75. Gill Hubbard et al., "Beyond Words Older People with Dementia Using and Interpreting Nonverbal Behaviour," *Journal of Aging Studies* (2002), 160.

76. "Consistent with this perspective, other researchers have suggested that behaviors may be a form of communication; a way that individuals with dementia seek to express themselves and their experiences." Dupuis, *Pathologizing Behavior*, 163. "Taking care of other people and treating them with dignity is not dependent on spoken words. This is an appropriate starting point for the chaplains' work among people with severe dementia." Jari Pirhonen, Auli Vähäkangas, and Suvi-Maria Saarelainen, "Religious Bodies–Lutheran Chaplains Interpreting and Asserting Religiousness of People with Severe Dementia in Finnish Nursing Homes," *JAL* 3.1 (2023), 97.

Sensing the Sacred

Since one's discernment of the body of Christ must be communicated to be acknowledged by a pastor, and since behaviors are the primary form of communication for nonverbal PWD, pastors should seek to understand what is being communicated by a PWD concerning the recognition of the body of Christ rather than assume that they are incapable of discerning the Sacramental Presence of the Lord's body on the premise that the deterioration of cognitive and semantic ranges disqualifies a PWD from proper examination. Instead, the pastor should consider the PWD's nonverbal communication to determine whether they discern the body and blood of Christ in the Sacrament. C.F.W. Walther advocates for a similar position in his *Pastoral Theology* when he quotes Luther saying, "So if they are rational and one can perceive from definite signs that they desire it from the correct Christian's devotion, as I have often seen, one should leave the Holy Spirit's work to Him and not deny Him what He requires. It may be that they internally have greater understanding and faith than we which no one should maliciously resist."[77]

What does discerning the body of Christ look like in nonverbal communication? While orthodox Lutherans tend to have little experience with a PWD's reaction to Holy Communion because of the Reformers' paradigm, other confessions, including other Lutherans (who hold to a lower view of the Lord's Supper) have made comments on the nonverbal reactions of PWD to Holy Communion. One such observation can be found in an article produced by the Lutheran church of Finland entitled, "Religious Bodies" which attempted to show the "religiousness of

77. Walther, *Pastoral Theology,* 147.

people with severe dementia in Finnish nursing homes."[78] Here are some observations from those who distributed communion to people with severe AD:

> One clear clue regarding residents' potential religiousness was their fumbling for liturgical rituals.… In the Finnish Lutheran context, the rituals are mainly based on services that contain repeated elements. People are used to clasping their hands for prayer, holding a hymn book, singing together, sitting and standing according to the liturgy, kneeling for Holy Communion, and so on. Residents with severe dementia were able to at least fumble these rituals, as Tiina expresses: For example at Communion, when you can't really tell from a person if they are here or there, but when it gets to it, or when they have made the utterances of Christ's body and so forth, the mouth will open like young chick's, for example. If they had been asked if they would like to take Communion they would not have understood, but these certain things trigger this in a way.[79]

While holding one's mouth open for a wafer, feebly genuflecting, or attempting to kneel are hardly dogmatic statements, these actions do show that the potential to not only remember what Communion is but to also remember the actions associated with the rite, exists even among people with severe AD. What the participating people with severe AD were communicating by "fumbling the rituals" was their recognition that not only was something sacred happening, not only was something out of the ordinary taking place but that they wanted to be a part of what was going on. They could tell that the wafer and the cup held by the man wearing a vaguely familiar black robe and white collar weren't just snacks.

For a LWD, the ability to discern the body and blood of the Lord in the Supper is the first aspect of examination that can be inhibited by dementia.[80] As mentioned previously, the

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78. Pirhonen, *Asserting Religiousness*, 92.

79. Pirhonen, *Asserting Religiousness*, 98.

80. The author acknowledges the reality that someone can lose their faith. The point of this statement is to show that the ability to discern the body and blood of Jesus in the Sacrament is directly correlated to the stages of AD. If a person with AD lost their faith, it wouldn't be because they had AD. The impediment to the Means of Grace caused by AD would be a contributing factor, however, one cannot say AD itself caused a loss of faith. What can be said is that the deterioration of cognitive abilities caused by AD can be responsible for a LWD's inability to discern the body of Christ.

diagnosis of dementia does not nullify the Word's efficacy, the Holy Spirit's preservation of faith, nor the LWD's penitence; however, there may be times when dementia prevents someone from either communicating their recognition of the body and blood of the Lord or recognizing the rite itself. The officiant of the Sacrament does have the responsibility of withholding the Eucharist from those who are unable to discern the body of Christ, but this judgment call should be made based on what the LWD is communicating not only with their words but also their actions.

Autobiographical Memory

Concerning the discernment of the body of Christ, recent studies on the topic of episodic and semantic memory have shown that the elements in the Lord's Supper may be more comprehensible to LWD than the spoken Word. In a study called "Episodic Memory," John Hodges and Kim Graham studied the correlation between semantic memory and recollection memory and the possible links between the two. In the course of their experiments, they discovered that "recognition memory for pictorial stimuli (pictures of objects, animals, and faces) is preserved in many patients with semantic dementia…"[81] What their conclusion shows is that PWD can retain an understanding of an object even if they have forgotten the words associated with said object.

The implication of this study on the distribution of Holy Communion is that while a LWD may have forgotten the words of institution and lack the semantic range to understand the

81. John R. Hodges and Kim S. Graham, "Episodic Memory: Insights from Semantic Dementia," ed. A. Baddeley, M. Conway, and J. Aggleton, *Phil. Trans. R. Soc. Lond. B* 356.1413 (2001), 1431.

proclaimed Word, they will likely be able to identify the elements in the Supper and their purpose. The extrapolations from the study are supported by Pirhonen et al. when one of their interviewees noted,

> Physicality becomes important, touch and all, even the Holy Communion is physical then, the taste of the wine, lack of taste of the bread…The above examples show that rituals are strongly embodied experiences and they carry symbolic and existential meaning. Rituals that can be touched and smelled invite people with dementia to participate more easily than rituals performed by words alone.[82]

The impact of the elements in the Lord's Supper is the same for all people, including LWD. What differentiates the Lord's Supper from the verbal proclamation of the gospel is the inclusion of all the senses. For sinful humans who are quick to doubt promises, God gives them, in the Supper, tangible promises that are difficult to dispute. In other words, a hearer of the gospel can argue that the pastor's words aren't meant for her, however, she can not argue that the words "take and eat" and "take and drink" aren't meant for her when she consumes the bread and the wine. For a person living with semantic dementia, the impact of the elements is even greater. Since the Lord's Supper is the visible Word, Holy Communion will statistically communicate the gospel to a Lutheran with semantic dementia longer than the spoken Word.

Appropriation

The last element of proper self-examination to be discussed is the matter of appropriation. The importance of appropriation is found in the words of institution themselves: "given for you" and "shed for you." Martin Luther explains the necessity of appropriation when he speaks about worthy reception in his Small Catechism, "Fasting and bodily preparation are in fact a fine

82. Pirhonen, *Asserting Religiousness*, 97–98.

external discipline, but a person who has faith in these words, 'given for you' and 'shed for you for the forgiveness of sins,' is really worthy and well prepared. However, a person who does not believe these words or doubts them is unworthy and unprepared, because the words "for you" require truly believing hearts."[83]

If self-appropriation is part of proper examination, how does one express that appropriation? For those who have the cognitive ability to do so, they show they appropriate Jesus' words by deciding to stand up and walk to the altar to receive the Sacrament. For those who are unable to make it to church and receive communion privately, they show they appropriate Jesus' words by their willingness to have the pastor visit, their outstretched hand which takes the wafer and the cup, and their "thank you" before he leaves. All these actions are public displays that indicate to a pastor that the recipients of the Supper know that Jesus' body and blood are "for you." If that's how able-minded members show that they appropriate Jesus' words, what does appropriating the Lord's Supper look like for LWD? The answer to the question and other PC considerations concerning appropriation will be discussed below.

Emotions

Just as behavior is one form of communication for people with semantic dementia, the display of emotions is another. When caring for PWD, emotions often communicate better than behaviors. Where caregivers are at a disadvantage to what a PWD might be thinking, they have no trouble with what they might be feeling on account of the universality of emotions. Anger is anger.

83. Kolb, *Book of Concord,* 363.

Happiness is happiness. Sadness is sadness. Emotions don't look different for PWD than they do for the rest of society.

Caregivers and pastors alike have noted that religious interactions have an intrinsic emotional sway for PWD. The most effective among the religious elements used with PWD are popular hymns, prayers, and Communion.[84] This tendency for worship and the Word to emotionally move PWD suggests that they are not merely hearing the words, but there is a level of understanding and personal application as well, causing the emotional reaction.

Coercion

On the negative side of appropriation is the issue of coercion. Luther makes it clear that while partaking of the Supper is a critical part of the Christian life, there is no room for coercion on the part of the pastor: "But we neither force nor compel anyone, nor need anyone do so in order to serve or please us. What should move and induce you is that he desires it, and it pleases him."[85] Coercing someone to commune is analogous to arguing someone into believing. Faith and desire come not from law or logic, but it is only through the gospel that the heart longs for the Savior and for the Supper.

Not only is coercion contrary to orthopraxy, but Communion coercion also violates PC care principles. As a person, a PWD has all the rights of a person, which includes the right to

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84. "Communion was perceived by all participants as the most significant ritual for churchgoers…." Kennedy, *Christian Worship Leaders*, 592. "Furthermore, participants recommended simple hymns be included in services to allow PLWD to further engage in worship. "The music...Jesus Loves Me, this I know, everybody knows that song, and so, he does...some simple songs... 'cause we do several songs, but he makes sure that he puts a simple song in there that they can enjoy." Fayron Epps et al., "Designing Worship Services to Support African-American Persons Living with Dementia," *J Relig Health* 59.4 (2020): 2163–76, https://doi.org/10.1007/s10943-020-00993-x, 2168. "All the interviewees had witnessed how residents often got very emotional during prayer services." Pirhonen, *Asserting Religiousness*, 97.

85. Kolb, *Book of Concord,* 472.

make choices and have their preferences matter. In the case of Communion, the PWD has the right to be considered for reception on account of their membership in the church and has the right to disqualify themselves by either the lack of proper examination or the lack of desire. It is only through these opportunities that a LWD, like any other believer, can appropriate the Lord's Supper and know that it's "for you."

Dignity

As you have read this paper, you may have noticed that I have refrained from relating people with AD to little children. This decision was intentional. Though in many ways, people with AD have similar deficiencies to little children, they are not little children. Understanding this point is crucial, not only for administering care to PWD but also for the conversation about administering the Lord's Supper to LWD.

While the Reformers and Synodical Conference were unclear about who was included among those "unable to use their mind," they were clear on the exclusion of children from the Lord's Table.[86] The argument has been made that since children cannot commune, LWD should not be allowed to commune either. This modern comparison between children and LWD is taken too far when it is used as the rationale for excluding LWD from Holy Communion for the following reasons: First, unlike children, LWD are adults who have extensive histories of their own which include a confirmation into the church and a public reception into membership.

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86. Excluded therefore are children, the sleeping, the unconscious, the dying deprived of the use of their senses, the insane and possessed while not in their right mind, etc." Pieper, *Christian Dogmatics,* 383. "Since according to God's Word everyone who would approach the Lord's Table should first examine himself and discern the Lord's body, it will not do to give the Lord's Supper to children incapable of examining themselves…. Walther, *Pastoral Theology,* 190.

Second, many LWD, before the onset of dementia, had received the Lord's Supper to their benefit for many years. Third, there is respect due the elderly and a dignity that every LWD possesses as an aged member of the church that children do not have.[87]

Caregivers seek to maintain dignity, not only for the sake of personhood but also for the sake of care. A practical example of this belittling is known as elderspeak. Because of the association of PWD to children, the practice of speaking to PWD like you would to a child has become common among caregivers.[88] Elderspeak comes in different forms. The most common form is "baby talk;" where a caregiver raises the pitch of their voice and speaks in a sing-song manner as one would to an infant. James McKillop cautions against other forms of elderspeak when he says:

> The tone and volume of your voice is important. Many people who are older, have hearing difficulties. Do not talk too quietly, screech at them or flap your arms about. Find the level at which the person can hear you clearly and maintain that level. The pace is equally important. Do not talk too fast, nor talk slow like this; Good…morning…how…are…you…today. It is demeaning.[89]

A 2009 article titled "Elderspeak Communication" analyzed the impact of the communication method on dementia care and found that "...nursing home residents with dementia are

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87. "Alzheimer's disease may strip away the memories that help construct a person's identity, but it does not strip away that person's intrinsic value or the right to dignity and respect." Jon C. Stuckey and Lisa P. Gwyther, "Dementia, Religion, and Spirituality," *Dementia* 2.3 (2003): 291–97, https://doi.org/10.1177/14713012030023001, 292. "I had some concerns about using a children's program with older adults. It was important to me to be respectful of the years they had experienced, and I didn't want them to feel that they were being talked down to in any way." Nancy Gordon, "Sensing the Sacred: A Small Group Worship Experience for Those with Alzheimer's and Other Dementias: A Conference Presentation from the 6th International Conference on Spirituality and Aging," *Journal of Religion, Spirituality & Aging* 30.4 (2018), 372.

88. "Ryan et al. describe how elderspeak derives from stereotypical views of older adults as less competent than younger adults and how elderspeak projects these stereotypes on elders. When younger adults talk with elders, they simplify speech and alter the emotional tone (underlying affective quality of messages). The implicit message of incompetence then begins a negative downward spiral for older persons, who react with decreased self-esteem, depression, withdrawal, and the assumption of dependent behaviors." Williams, *Elderspeak Communication*, 12.

89. McKillop, *Communicating with People with Dementia*, 334.

significantly more likely to exhibit RTC (resistiveness to care) when nursing staff use elderspeak communication compared with normal adult talk."[90] In other words, even people with severe AD know that they are different from children. As a spiritual caregiver, part of the pastor's responsibility is to reinforce a LWD's dignity, not by administering the Lord's Supper to them without examination, but by not refusing them the Lord's Supper under the assumption they are equivalent to children.

United

The final condition for being properly prepared to partake in the Lord's Supper is the matter of unity. Important to this unity is fellowship; both on the synodical and scriptural level. The scriptural basis for the expectation of unity among the participants of the Lord's Supper can be seen in Paul's explanation of the Supper in 1 Cor 10:16–17 and his rebuke of the divisions reported in the Corinthians' Communion practices in 1 Cor 11:17–22. With Paul's words to the Corinthians in view, the LCMS report "Admission to the Lord's Supper" speaks to the importance of unity among communicants in this way: "All who commune must examine themselves and through repentance and faith they must find the divinely created willingness to remove divisions and to preserve unity with fellow communicants…. Moreover, faith in the Sacraments benefits is also required, and especially its purpose to maintain the corporate identity and unity of the church as the body of Christ."[91]

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90. Kristine N. Williams et al., "Elderspeak Communication: Impact on Dementia Care," *Am J Alzheimers Dis Other Demen* 24.1 (2009), 19.

91. LCMS, *Admission to the Lord's Supper,* 19–20.

How, then, does AD affect the unity of PWD from the body of Christ? AD affects a PWD's unity with the church in three ways: First, it separates them doctrinally. Second, it separates them from their identity. Third, it separates them spatially. The impacts of AD on unity and their solutions will be discussed below.

Spatial Separation

One of the blessings of corporate worship, in addition to the edification that comes through Word and Sacrament, is the fellowship shared between believers as they sing together, pray together, commune together, talk together, etc. Humans are social creatures. Every person wants to exist in a place where they belong, where they are noticed, where they have a purpose. For many people, that desire for belonging is fulfilled in a church setting.

The innate desire to socialize doesn't disappear when someone is diagnosed with AD.[92] On the contrary, because of the solitary nature of the disease, the longing for belonging is only amplified among PWD. I observed this thirst for affection during my time working in the dementia ward. For example, one of my favorite parts of being a caregiver was the look on a resident's face when I was able to make a connection with them. Whether it was through a touch of the hand, the mention of a memory, or a smile, they communicated just how much they cherished those moments of real communication when they held onto my hand as tight as they could and wouldn't let go.

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92. "The progressing disease does not, however, frustrate the basic human need for affection… To maintain a sense of self, people need comfort, attachment, inclusion, occupation, and identity." Pirhonen, *Asserting Religiousness*, 93.

The unfortunate reality for PWD is that they do not retain the ability to live independently indefinitely. As the disease progresses, not only will their need for care increase but the level of care required will increase as well. As a result, the majority of PWD who reach late-stage AD end up in a facility designed to provide a level of care that is impossible in a home setting. While an assisted living facility or a nursing home might be better prepared to care for the physical health of a PWD, studies have shown that mental health often suffers as a result of living separated, not only from family but also from the world in which they used to live; a world that included church.[93] Kinghorn laments this separation when he says,

> Churches all too often acquiesce to these cultural structures, incorporating disabled or agency-diminished people (those whom in my childhood would be listed in church newsletters as "shut-ins") only through the auxiliary media of prayer lists and occasional pastoral visits. Churches, like social spaces in the culture as a whole, are all too often for the able-minded and able-bodied; others are overlooked and forgotten by all but a small number of family members and close friends.[94]

While the spatial separation between LWD and their church family is inevitable, the members of Lutheran congregations have an opportunity to mitigate the impact of that separation. Lutherans not only have a solution to a LWD's loneliness; they are the solution to a LWD's loneliness. The worship, fellowship, and camaraderie shared in the sanctuary and the narthex can also be shared in memory care units. All that is required to provide that unity is a sacrifice of time and the perspective that the LWD is not only a person who needs affection, but is also a fellow member of the church, both visible and invisible.[95]

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93. Rabins, *Practical Dementia Care*, 8.

94. Kinghorn, *Christian Wayfarer,* 99.

95. "On the contrary, those parts of the body that seem to be weaker are indispensable, and the parts that we think are less honorable we treat with special honor. And the parts that are unpresentable are treated with special modesty, while our presentable parts need no special treatment. But God has put the body together, giving greater honor to the parts that lacked it, so that there should be no division in the body, but that its parts should have equal concern for each other" 1 Cor 12:22–25.

Confessional Separation

While the fellowship shared between members in the sanctuary and the narthex is a manifestation of congregational unity, there is an even greater form of unity experienced at the Communion rail. Lutheran dogmaticians describe this unity as having two dimensions: one vertical and one horizontal. The vertical dimension of unity in the Lord's Supper is between God and the individual, while the horizontal dimension of unity is between the communicants. When communicants receive Jesus' body and blood in the Sacrament, they commune with God individually together and, in so doing, are brought close to God and each other. The unity necessary for both relational dimensions of the Lord's Supper is based on a mutual confession of faith; a confession that not only professes biblical doctrine, but a confession that acknowledges the sacramental presence of Christ's body and blood in the Supper.

For LWD, AD not only separates them spatially from their fellow church members, but it also separates them confessionally. Where the unity shared between fellow communicants is based on the confidence that those partaking in the Sacrament share a common confession, the presence of AD inserts doubts into that confidence. As the disease progresses, all outward signs of confessional unity diminish. It is in this worship apraxia that we see the travesty of an AD-induced separation of confession: The LWD is a victim of forced disqualification. While the majority of circumstances that disqualify a confirmed member of the church from receiving the Sacrament are self-inflicted, a LWD, through no fault of their own, passively loses the ability to publicly confess their faith and to participate in the worship life of the church, despite their faithful striving to be the Christians Christ called them to be.

When considering administering the Lord's Supper to LWD, pastors need to differentiate forced disqualification from sinful disqualification. Living with AD is not sinful nor do people

live with the disease because of a sin they committed in the past. For this reason, the pastoral judgment call of withholding the Lord's Supper from a LWD should be made with the greatest care and should be made from a heart of mercy. Consider how much effort goes into encouraging a delinquent member to repent before disqualifying them from the Lord's Table. How much more, then, should pastors be patient and understanding of those members who have AD?

Finally, while AD inevitably robs the LWD of the ability to participate in the worship life of the Church, pastors can take preventative measures to slow worship apraxia. One such measure is the frequent use of the liturgy: "In relation to non-verbal forms of memory (e.g. memories for actions, procedural memories), the use of familiar hymns and prayers and traditional visual symbols were perceived to act as automatic triggers to long-term, well-established memories (i.e. an automatic awareness of when to stand, sit, kneel, make a response, recite a prayer, etc)."[96]

As a testimony to the efficacy and the longevity of hymns and prayers for people living with severe AD, almost every conversation I had with a pastor on my topic included a personal pastoral experience where the LWD was incoherent and distant until he began to say the Lord's Prayer or read Ps 23. The LWD's familiarity with the Lord's Prayer and Ps 23 developed before they contracted the disease, not after. Additionally, the longevity of a particular hymn or prayer's ability to be recalled directly correlates to the frequency of its use in the life of a LWD before the onset of AD. This correlation exists not only for hymns and prayers but also pertains to entire liturgical rites:

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96. Kennedy, *Christian Worship Leaders,* 594.

> There have been cases where a person has been reached by singing “in the name of the Father, the Son, and the Holy Spirit” [to a tune used in Finnish Evangelical Lutheran liturgy]. Then the person has responded singing “amen, amen, amen.” That is rather remarkable. And they have felt very good and grabbed [my] hand. I remember, one person grabbed me by the hand each time they encountered something familiar as everything was so foreign to them.[97]

Therefore, if a pastor desires that LWD stay a part of the worship life of the church (which includes participating in the Lord’s Supper) into the late stages of dementia, he should introduce able-minded members to the Rite of Holy Communion as early as possible and expose them to that liturgy as often as possible so that, if the diagnosis of AD does come, they will be better equipped to not only participate but also to prepare for reception.

In response, one might argue that the liturgical movements that a Lutheran with severe AD makes are merely mechanical reactions to memories devoid of meaning. Kinghorn asserts that to view the actions of any PWD as purely mechanical is to rob them of their essential self.

> Modern commonplace descriptions of people with dementia are haunted by the image of the absence of an essential self: He’s not all there ... She’s just a shell of who she once was ... He’s not there, just his body ... She died a long time ago. Common to all of these phrases, which are uttered in Christian contexts as well as in the broader culture, is the presupposition that the soul or mind (one’s mental, cognitive, spiritual self) inhabits the body (which is conceived as space and extension); that something called “dementia” or “Alzheimer’s disease” has cut the link between the soul/mind and the body; and that what is left behind is not the “real” person but some “shell” of who he or she once was when the mind/soul fully inhabited the body.[98]

While it is true that no one knows exactly what a LWD is thinking as they go through the mechanics of the Lord’s Supper, they nevertheless possess the soul and body dichotomy that is essential to personhood. To view them as Christians incapable of meaningful worship would be to view them as less than human. In the same way, an able-minded Lutheran can mindlessly go through the mechanics of a liturgical rite and still receive the Lord’s Supper, so a LWD could go

97. Pirhonen, *Asserting Religiousness*, 98.

98. Kinghorn, *Christian Wayfarer,* 101.

through the mechanics of the Rite of Holy Communion and not disqualify themselves from the proper reception of the Lord's Supper.

A difference does exist between the able-minded member and the member with severe AD in how a pastor helps them prepare for receiving the Lord's Supper. Where an able-minded member might be encouraged to say a specific prayer or go through a series of examination questions before communing, these approaches might not communicate to a LWD. Instead, a pastor needs to consider the cognitive and semantic barriers to such preparation and instead help the LWD prepare for proper reception by using symbols. Since objects statistically communicate better to PWD than words, a pastor can reinforce the unity of LWD with the church while assisting them in preparation for the Lord's Supper by including the liturgical symbols associated with the church (e.g. alb, clerical collar, cross, candles, etc) in their visits. Kennedy speaks to the orienting ability of visual cues for LWD when she says, "For all participants music and visual cues such as color and symbols, the Bible, the cross and clerical collar, facilitated orientation to place and time."[99] Pirhonen et al. mentioned similar findings in their interviews:

> Earlier in the interview, Tarja described how people with severe dementia recognized religious symbols. A candle, a cross, and a Holy Bible on the table told people that something religious was happening. The clerical clothing, which Tarja wore, helped residents to orient themselves in the situation. When they were not fully cognitively capable of comprehending the situation, embodied cues helped people to follow the occasion…. All the interviewees wore clerical collars when visiting a nursing home to offer residents a clue of their role. Residents recognized the chaplains from their clothing and approached the chaplains with various subjects, providing the chaplains with chances to affirm the residents' religious convictions or give them comfort. The chaplains being visible was one more aspect of corporeality in affirming religiousness among people with severe dementia.[100]

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99. Kennedy, *Christian Worship Leaders,* 589.

100. Pirhonen, *Asserting Religiousness*, 99–100.

Even though there might be times when LWD seem to be confessionally separated from the rest of the congregation, the pastor should approach the issue with caution and mercy, realizing that the LWD is a victim of forced disqualification, and do all he can to help prepare the LWD for examination using the liturgy and its symbols.

Identity Separation

The final division that occurs because of AD is the separation of a LWD from their identity. Since the Lord's Supper is the Sacrament of Confirmation, it becomes the highest form of the Christian worship life. Only members of a church can partake in the Lord's Supper, and only of a kind that can properly examine themselves and are in good standing with the congregation. As a result, participation in the Lord's Supper becomes part of the Lutheran identity.

For Lutherans who have AD, not only will they inevitably be separated spatially and confessionally from the congregation, but they will also be separated from their identity as a member of the congregation, even while remaining on the membership roster. They won't be able to participate in the life of the church inside or outside the service. They won't be able to serve in all the ways they used to, talk to all the people they used to, and worship the way they used to. If losing their ability to live out their Lutheran identity wasn't bad enough, Lutherans with AD will not only lose the ability to do the activities, but they will lose the ability to recall the memories they made as part of the church as well.

The desire to maintain identity in PWD is one of the major focuses of PC care for a reason: identity leads to life. For LWD, this life includes not only physical life but also spiritual

life.[101] Luther speaks of the importance of the Lord's Supper in the life of a Lutheran when he says,

> Now it is true, as we have said, that no one under any circumstances should be forced or compelled, lest we institute a new slaughter of souls. Nevertheless, it must be understood that such people who abstain and absent themselves from the sacrament over a long period of time are not to be considered Christians. For Christ did not institute the sacrament for us to treat it as a spectacle, but he commanded his Christians to eat and drink it and thereby remember him.[102]

The Lord's Supper is an integral part of the Lutheran identity, and though a LWD might not be able to identify its absence, they are nevertheless impacted by the spiritual vacancy. While the preservation of identity should never come at the expense of orthopraxy, a pastor, who has been charged with the spiritual care of a member with AD, needs to keep the intimate relationship between spiritual identity and longevity in mind when deciding how to provide pastoral care. Should the Lord's Supper be withheld from a LWD, it is the spiritual caregiver's responsibility to fill that hole in the Lutheran's identity with an ample measure of the gospel to provide the wholistic spiritual care that every Christian needs.

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101. Religiousness may slow the progress of early-stage dementia by offering cognitive activity and social support. Studies of Christians with dementia show that belief in God gives them comfort and maintains their identity. Pirhonen, *Asserting Religiousness*, 93.

102. Kolb, *Book of Concord,* 471.

CONCLUSION

Of the hundreds of thoughts that might run through a pastor's mind when considering when to administer the Lord's Supper to LWD, he would do well to keep in mind the following: First, not all LWD have the same capacity for examination. There are different types of dementia as well as different stages of each dementia which all have different impacts on one's ability to examine themselves. Second, the member who has dementia is not only a person, but also a member, and thus deserves to be treated with the dignity of a person and a member, especially when considering whether they should partake of the Lord's Supper. Third, the reality that a LWD perceives and communicates differently than able-minded members does not mean that they do not perceive and do not communicate, nor is their perception and communication any less valid or valuable. Because of this differentiation of perception and communication, a spiritual caregiver needs to meet LWD where they are by using perceivable methods of communication, by being patient as they determine their ability to examine, and by utilizing familiar rites, rituals, and symbols common to the worship life of the Church.

In conclusion, the question "When do you administer the Lord's Supper to Lutherans with dementia?" doesn't have a black-and-white answer. The administration of the Lord's Supper to LWD is a matter of casuistry; however, the judgment call to withhold the Lord's Supper from a LWD should be based on a PC approach to spiritual caregiving. No member of the church should be disqualified from participation in the Sacrament based on a diagnosis or an assumed level of understanding. Instead, the inclusion or exclusion of a LWD from the Lord's

Table is to be based on the same standards required of the rest of the congregation. Part of maintaining the personhood of a LWD is allowing them to display their proper preparation for the Supper, or lack thereof, and thereby disqualify themselves. Therefore, the answer to the question is not a line of demarcation, but a frame of mind. A pastor should be forced to withhold the Lord's Supper from a LWD instead of looking for a reason to withhold the Sacrament from a LWD.

The only way that a spiritual caregiver can determine whether a person can discern the Lord's body and blood and properly partake of the Sacrament is by offering it to them. By offering the Lord's Supper, not only verbally, but also visually, a pastor will be better informed whether a LWD can receive the Sacrament to their benefit. If the spiritual caregiver asks a LWD if they would like to receive Communion while holding out the elements to them, and they do not indicate recognition and desire, whether verbally or behaviorally, then the Supper should be withheld. However, if a LWD displays discernable recognition and desire, a pastor should administer the Lord's Supper with a clear conscience because, in that moment, the memory care room is an extension of the church's communion rail occupied by another Lutheran to whom Christ says, "given for you; shed for you."

Recommendations

Based on my research, I have a few recommendations concerning pastoral care for LWD. First, I would recommend that the examples of those incapable of examination given in the WLS dogmatics notes be amended. Categorically stating that people with AD and "senile dementia" are to be excluded from the Lord's Table inevitably excludes people with AD who are still able to examine themselves. Additionally, the use of both terms is out of date and does not match

current literature. Second, I would recommend that in-reach to LWD, especially if they cannot receive the Lord's Supper, be more than a simple shut-in call. Instead of merely visiting a LWD, worship with a LWD. Therefore, I suggest that the question, "How can pastors bring LWD into the worship life of the church?" be pursued for further study. Finally, I would like to encourage patience when caring for PWD in general. Being a caregiver for PWD, even a spiritual caregiver, is difficult and tiring work; however, it is in that difficult and tiring work that pastors can help walk of Jesus' frailest sheep to his arms where body and mind will be restored forever.

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