THE EFFECT OF MONTESSORI-STYLE, MULTI-SENSORY WORSHIP ON THE AFFECTIVE EXPERIENCE OF WOMEN WITH DEMENTIA

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CHAPTER 1

PROBLEM STATEMENT

A prominent feature of Alzheimer's disease (AD) and other forms of dementia was deficiency in cognitive processing. Yet, even in long-term care facilities specializing in patients with dementia, providers of religious services often relied upon spiritual activities that depended upon cognition. In the professional literature, Richards and Seicol 1991, O'Connor 1992, Wentroble 1999, and Weaver 2002 asserted that cognitive approaches were not likely to help dementia patients access their spiritual memory or find meaning in the experience.

Persons with dementia typically did not remember what happened in recent history. AD victims often did not recall what was learned in the past five, ten, or twenty years, but usually retained long-term memory. Early learning remained intact long into the disease process. The challenge was to tap into early learning to assist those with cognitive impairment remember their spiritual beginnings.

The question this research sought to answer was: Would people with dementia respond with a higher level of engagement and more positive affect when presented with worship experiences that engaged several of the senses than they would respond to traditional ministry visitation? The research approached this question by developing and testing two ministry styles that used multi-sensory methodology advocated by Maria Montessori for use with children who had mental deficiencies. Although Montessori's

methods had been researched with dementia patients in recent years, the focus was on their engagement with activities. Montessori methods had not yet been applied to the spiritual needs of the dementia-afflicted elderly.

Montessori developed an approach to education that assisted mentally disabled children to grow in cognitive, social, and functional skills. Using the senses—sight, hearing, touch, taste, and smell—Montessori was able to broaden the horizons of children who had been considered uneducable.

The senses are of great importance in childhood—children are constantly touching, tasting, and noticing colors and shapes. The senses also become extremely important to the person with dementia. Camp (1999) was one of the early researchers who connected Montessori's methods of working with children to research and care of people with dementia. Just as Montessori believed in the potential of children who were considered mentally deficient, Camp believed that victims of Alzheimer's disease could grow and learn. The results of Camp's research validated his belief.

The purpose of the current study was to ascertain to what degree multi-sensory methods could enhance the spiritual experience of people with dementia. Engagement and affect were measured during two styles of multi-sensory ministry visitation and compared with engagement and affect during a traditional ministry visitation.

Chapter 1 provides a brief overview of the entire research project. Chapter 2 reviews the literature that forms the theoretical and methodological foundation for the study, which is described in detail in chapter 3.

Background of the Problem

Individuals with dementia had an ongoing need to engage in meaningful activities. For those with a lifelong history of religious faith and practice, spiritual activities were often more meaningful than any other kind of activity. There are those who believed that it was not necessary to provide religious programming to dementia sufferers because they did not understand or remember the lessons later. The Rev. James Graham (1999) stated that church visitors often equated reduced cognitive ability with decreased emotional and spiritual capability. However, many dementia experts (Adelsber 1995, Stuckey 1998, Richards 1990) believed that if spiritual faith and practice were once important to a person, cognitive deficits did not erase the need to engage in meaningful spiritual activities.

Due to cognitive deficits, it was often difficult for people in mid-to-late stage Alzheimer's disease (AD) to remember former religious beliefs and practices. Traditionally, religious programming had been cognitively based, utilizing such methods as sermons, Bible readings, and responsive readings (Everett 1996). Many church congregations brought a similar type of programming to people in nursing homes and to homebound visitation programs. Relatively alert residents responded well to those programs, however, people with dementia found cognitively based programs difficult to follow.

Research by a Calvin College professor demonstrated that people with dementia lost the ability to follow sermons and text-based presentations. Weaver declared that just when they most needed it, people with Alzheimer's disease found it difficult to feel God's presence and assurance (Weaver 2002).

Stuckey and other participants of a 1998 dialogue agreed that even deep into dementia a person had the capacity for meaningful spiritual experiences. Stuckey concluded that spiritual matters should be incorporated into the plan of care as part of the "treatment" that could help individuals deal with their dementia (Stuckey et al. 2002). Stuckey asserted that religious programming must, however, be presented in ways that did not rely on cognition in order to fully benefit the person with AD.

People with dementia responded to sensory stimulation when they could not respond to cognitive cues. The use of multiple sense modalities were employed by Maria Montessori to assist learning disabled children grow and learn. Camp and associates (2000) took some of the Montessori principles and applied them to individuals with Alzheimer's disease. Camp found that, like Montessori's work with children, people with dementia were stimulated to learn and grow when sensory stimulation was applied. Although there were other tenets within Montessori's work, the current research focused on the sensory aspects.

The Purpose of the Research

Stuckey (2002) insisted that religion and spirituality were important capacities that must remain available to persons with AD until the end of life. Stuckey reported that although the person with AD had trouble communicating feelings, a connection with the spirit could be maintained. Stuckey asserted that spirituality brought comfort to both the diagnosed and their families, brought meaning to an otherwise meaningless situation, and helped sustain individuals as they traversed the confusing path of dementia.

Stuckey observed that religion could not be used in the same way that medications or other therapies were used to help people cope with the disease, but it had

significant power. Stuckey maintained that people with dementia who had been given spiritual care responded in positive ways, and whenever possible they should be given opportunities for worship throughout the dementia experience (Stuckey 2002).

If cognitively based worship experiences did not hold much meaning for the person with AD, other methods were needed to help the Alzheimer's patient access his or her religious memory. Some pastors and other professionals who have worked with the confused elderly have tried various approaches of religious programming. Many professionals have reported positive results when they used sensory materials, familiar hymns and prayers, and nature in religious programs.

Some empirical research was reported on the use of music in worship (Kirkland 1999, Aldridge 1994), but little empirical research was available on the use of multi-sensory modalities in worship. Stolley, Koenig, and Buckwalter (1999) asserted that it was time to promote research in spirituality and dementia. Stolley et al. stated that those involved in pastoral care should become participants in investigating the use of religious activities to provide comfort to those with dementia. Stolley further suggested that pastoral care workers could help determine what methods of presentation were most effective for people with AD.

An underlying theory was needed to guide religious programming for people with dementia. A small body of research demonstrated the effectiveness of using Montessori-style methods to present activities to people with dementia. Camp and associates researched the Montessori-style methods for several years and reported increased positive affect and engagement in individuals with dementia when using Montessori methods (Camp 1999, Orsulic-Jeras, Judge, and Camp 2000). Although Camp did not venture

into the worship experience with his research, the Montessori techniques could be employed in the presentation of religious programming and pastoral visitation. The current study focused on the multi-sensory aids that were important to the Montessori method.

The purpose of the present research was to explore whether two styles of multi-sensory ministry visitation (MMV) would result in more positive affect and engagement than the traditional ministry visitation (TMV), in which an attempt was made to engage the individual in conversation, to offer a lesson verbally, and to end with scripture and prayer for the individual. Pleasure, or affect, and alertness, or engagement, were measured during the experimental treatment with the aid of the Observed Emotion Rating Scale (Lawton et al. 1999).

Significance of the Research

It is estimated that four million Americans have Alzheimer's disease or related dementias. People with dementia suffer many losses. The loss of the ability to find comfort from former religious beliefs and practices can be devastating to the victim of AD and to family members, who are often more acutely aware of the loss than the person with the disease. If pastoral visitors would learn a new way of reaching out to the confused elderly and if ministry workers were able to remind the demented of God's love by helping them connect with their spiritual memory, the quality of life of dementia patients would be profoundly improved. The use of Montessori-style methods had the potential to bring individuals with Alzheimer's disease a sense of peace and reassurance and help them access their spirituality once again.

The implication for the church is that members could minister more effectively to the individual with AD, whether visiting in a nursing home, within the congregation, or in home visitation. A tool, such as one of those suggested in this research, would diminish some of the discomfort and uncertainty laymen feel when visiting the demented. Since Alzheimer's disease affects the entire family, more effective ministry with those suffering from the disease would positively impact other family members as well.

Research Hypotheses

Using a quasi-experimental model, two hypotheses were tested. Hypothesis 1 examined the influence of mode of visitation upon observable affect, and hypothesis 2 tested the influence upon alertness.

Hypothesis 1 (H_a1): There was a significant difference between the effects of Traditional Ministry Visitation (TMV), Multi-sensory Ministry Visitation-Book (MMV-Book), and Multi-sensory Ministry Visitation-Object (MMV-Objects) on the observable affective experience of women with mid-stage dementia as measured by the Observed Emotion Rating Scale (OERS).

Hypothesis 2 (H_a2): There was a significant difference between the effects of TMV, MMV-Book, and MMV-Objects on the alertness of women with dementia.

Chapter Summary

Individuals with a history of religious faith and practice continued to need spiritual connectedness even in the depths of dementia. Ministry teams must understand how to help people with dementia make that spiritual connection. This research tested the effectiveness of multi-sensory tools to aid the process.

CHAPTER 2

REVIEW OF LITERATURE

According to the Alzheimer's Association (2003), dementia was the umbrella term for a set of symptoms related to a decline in thinking skills caused by the gradual loss of the functioning of brain cells. Possible causes of dementia included a series of strokes, Parkinson's disease, infection, alcohol usage, and other disorders that destroyed brain cells. Some causes of dementia, such as thyroid problems, vitamin deficiency, or reaction to medication were treatable or reversible if diagnosed in time. Alzheimer's disease (AD) was the leading cause of dementia and was not reversible. Because symptoms were similar, this study included participants who had either AD or other related dementias. The terms AD and dementia were used interchangeably throughout this study.

It was estimated that four million Americans suffered from AD or a related dementia. About ten percent of people over the age of sixty-five and up to half of those over eighty-five years of age were thought to have some form of dementia. With the increasing population of elderly citizens, it was estimated that by the middle of this century fourteen million Americans would suffer from AD (American Association for Geriatric Psychiatry 2002).

Common symptoms of AD included gradual loss of memory, especially of recent events, problems with reasoning or judgment, disorientation, difficulty learning, loss of

language skills, and decline in the ability to perform routine tasks. People with dementia often experienced changes in personality and sometimes exhibited behavioral manifestations such as agitation, anxiety, delusions, or hallucinations.

The duration of Alzheimer's disease was different for each victim, ranging from three to twenty years and progressing at varying rates. The Alzheimer's Association described three stages in the progression of the disease. In the early stage which lasted from two to four years, the areas of the brain that control memory and thinking skills began to be affected. Loss of memory interfered with the person's work performance or in managing tasks in the home. Personality and mood changes often occurred. Diagnosis was often sought when performance, mood, and personality changes became noticeable.

The second and longest stage of the disease lasted from two to ten years. Memory loss and confusion worsened. The individual often became more restless and agitated. Logical thinking and the organization of thoughts became increasingly difficult, and the right words for objects often eluded the person.

As the disease progressed, other regions of the brain became affected, and the person with AD eventually needed complete care. The terminal stage lasted from one to three years. Individuals lost the ability to care for themselves or to communicate. People with AD often died of an infection or pneumonia. The loss of brain function eventually caused death if other conditions did not.

Activities and Quality of Life in Alzheimer's Disease

According to the American Association for Geriatric Psychiatry (2002), the primary goals of treatment for individuals with AD were to improve the quality of life and to maximize functional performance by enhancing cognition, mood, and behavior.

The Association maintained that stimulating memories of past relationships helped this process.

All people benefited from the stimulation that was produced by appropriate activities. Engagement in meaningful activity was a fundamental human requirement that was critical to the health and psychological well-being of humans (Pertin 1995).

Those with Alzheimer's disease needed meaningful activity no less than other individuals. Cholewinski and Williams addressed the importance of meaningful activity for people with dementia at the March 2003, Joint Conference of the National Council on Aging and the American Society on Aging. Cholewinski and Williams asserted that patients should be engaged in activities that reflected their interests and lifestyle and were respectful of their beliefs, culture, and values. Activities should cover four life domains: (1) productivity or work, (2) leisure or relaxation and fun, (3) self-care or activities of daily living and instrumental activities of daily living, and (5) insightfulness or self-growth and spiritual.

Individuals with AD benefited from continued activity in the four domains in several ways. Mace and Rabins (1981) explained that a variety of activities helped the person with dementia physically but also helped him or her feel as if life still held meaning. Zgola (1987) stated that a decline in cognition forced people with AD to withdraw from activities that once reinforced their identity. Assistance in maintaining meaningful activities and relationships helped strengthen their self-image and reminded them who they were and how they related to others.

Mace, Rabins, Zgola, and others pointed to what Kitwood (1997) called "person-centered care." Person-centered care required that the person be viewed as an individual,

with unique needs, interests, and abilities, no matter what the stage of dementia. Kitwood wrote that when personhood was emphasized in models of care, there was also an emphasis on dignity and individuality. In person-centered models, Kitwood believed, there was the inherent implication of the value of the human spirit, which also implied that issues of religion and spirituality in dementia needed to be addressed (Kitwood 1997).

Bowlby (1999) believed that since religious activities were an important part of the life experience, they were essential to holistic treatment of the individual. Bowlby asserted that religious activities were a source of support and reassurance, were familiar adult activities that strengthened the individual's sense of self, and they represented a unique way of communicating.

In the past, physical aspects such as symptom management were the major focus of dementia care. As Kitwood (1997) remarked, focusing only on the physical aspects of the disease meant that other areas, such as spiritual well-being, were too often neglected. Whether treatment was labeled holistic or person-centered, the inclusion of activities in all four domains enhanced the quality of life for people with dementia. For all individuals with a faith-based background, quality of life was strongly connected to spiritual belief and practice. The need for spirituality did not necessarily end with the onset of AD as the next section will demonstrate.

Importance of Religion for People with Alzheimer's Disease

As people aged, religious faith and practice became increasingly important. In a 1991 poll, approximately seventy-five percent of people over the age of sixty said that religion was important to them. The figure was even higher in the Southeastern states

(Koenig et al. 1991). In addition, both research and clinical observation have recognized that spirituality was a contributing factor to the well-being of older adults (Koenig 1988, 1990; Guy 1982; Levin 1989).

The Joint Commission on Accreditation of Health Care Organizations (JCAHCO) recognized that religious faith and practice impacted many people's quality of life. As part of the overall assessment process, JCAHCO facilities were mandated to do spiritual assessments as well as physical, psychological, and social assessments.

Koenig stated that the capacity to trust, or have faith, was one of the first psychosocial tasks learned in life and one of the last to depart at the end of life. "Even with advancing cognitive impairment, the ability to participate in relationship with God is one of the last human capacities to be lost before consciousness itself ceases" (Koenig 1994, 133).

Stuckey 1998, Adelsber 1995, and Richards 1990 were among those who noted that if spiritual faith and practice were once important to people with dementia, cognitive deficits did not erase the need to engage in meaningful spiritual activity. Anecdotal reports from gerontologists, clergy, and healthcare professionals demonstrated that people with dementia continued to respond to religious cues that rekindled memories of past faith experiences. Examples of anecdotal reports that demonstrated the meaning of religion for the confused elderly follow.

Richards (1990) reported that although a woman with mid-stage dementia did not know where she lived or what day it was, she responded accurately to symbolism. The woman entered the chapel and said that she knew that it was Reformation Sunday

because "The pastor is wearing red." Richards asserted that many people with dementia continued to respond to faith rituals and symbols.

Researchers at the University of Oklahoma Health Services Center and Manchester, New Hampshire VA Medical Center, hypothesized that spiritual beliefs were relevant to the treatment of people with Alzheimer's Disease. Khouzam (1994) described a seventy-three year old man who demonstrated physical aggression and agitation when he had episodes of incontinence. Due to severe cognitive deficits, attempts at behavior modification failed. The man's son visited each week, and although the man did not recognize him, he seemed noticeably calmer after the son read Biblical passages during the visits. A nurse heard the patient reciting a Biblical passage to himself after an episode of incontinence and observed that he remained calm rather than becoming agitated as usual.

It was learned that the verse held spiritual meaning to the man during his World War II experience. The staff tried repeating the verse to the father whenever he became agitated. In six weeks, during which the treatment of Bible Beliefs Therapy (BBT) was implemented, episodes of agitation decreased from eight episodes a day to only two per day, and by the end of the eighth week, the aggression and agitation had subsided even when he had incidents of urinary incontinence.

Another man with Alzheimer's disease, who had been a prisoner of war in World War II and whose religious faith kept him from committing suicide during that time, displayed increasing agitation, disorientation, and physical aggression toward the nursing staff. A nurse who overheard the patient repeating a Bible verse to himself tried Bible Beliefs Therapy. The resident’s agitation gradually subsided when the Bible verse was

repeated. The agitated behavior was reduced from seven to two occurrences in the first week, one episode in the second week, and none after the third week (Khouzam et al. 1994).

The operators of four clubs for impaired elderly in Jerusalem observed that there seemed to be an awareness of a Higher Being in the demented population. Abramowitz explained that at Melabev they offered dance, art, music, physiotherapy, a social hour, group discussions, and celebrations, but one of the most valuable parts of the program was the daily prayer session. The atmosphere during prayer time was quiet and respectful. Prayers, printed on laminated, large-print sheets, were handed out, and a group member led the reading. Abramowitz stated that family members were often amazed when a parent or spouse, who had not attempted to read in years, began to read aloud. People who did not respond to other activities frequently responded to familiar songs and prayers (Abramowitz 1993).

In several studies, individuals who suffered from dementia communicated that faith helped them deal with AD. Snyder (2003) interviewed twenty-seven people with dementia to determine what role religion or spirituality played in coping and in finding meaning in life. Snyder also probed into the influence of dementia on religious practice and on faith. Many informants commented that their religion continued to be a comfort to them. One Catholic man explained that although he could no longer remember the prayers that he had once recited automatically, God continued to connect with him in a meaningful way. Some of the participants expressed fear that they would someday be unable to remember God's promises (Snyder 2003).

As both professionals and people with dementia attested, there was a need to reach beyond the bonds of dementia to help confused elderly persons access moments of spirituality. Even if those moments were brief, there was the possibility of bringing an occasional glimpse of God's continuing love for them. Those moments might offer a little peace and light in the midst of a dark disease.

The moments when individuals with dementia were helped to access their spiritual memory benefited them in many ways. Wentroble (1999) believed that when pastoral care helped a person with AD retain connections to people, words, rites, rituals, music, and pictures, the individual maintained a spiritual base from which to draw inner strength. Adelsber (1995) noted that religious observances linked the confused person with his/her former self. Alzheimer Association spokespersons, Bell and Troxel (1999), said that music, nature, and religious faith traditions and rituals nurtured the human spirit.

Dowling (1995) reported that although it was difficult to evaluate the spiritual needs of individuals with dementia, the attentiveness of participants in dementia-appropriate worship services was testimony to the value of structured worship. He explained that no other activity produced the kind of peacefulness in the dementia patient that he observed during worship activities.

In a qualitative study of persons with early stage Alzheimer's disease (Harris and Durkin 2002), a number of individuals with AD said that their spiritual beliefs were a source of comfort and support to them. Harris and Durkin reported that people with early stage AD employed a variety of positive coping behaviors, including drawing on their spirituality, to meet the challenges and stresses of living with dementia. These coping

behaviors provided the dementia patients with hope and a sense of control over a devastating illness.

In another study of early stage dementia patients, a significant relationship was found between faith in God and perceived quality of life (Katsuno 2003). Most of the twenty-three participants of the study expressed a strong faith in God. Their faith sustained them in their illness and provided strength and comfort.

The experience of spirituality and religion in the lives of people with AD and their caregivers was explored in a 1998 focus group as part of a community dialogue. Stuckey and associates (1998) claimed that even deep into dementia a person's capacity for spiritual experience remained meaningful to them, and they continued to be capable of maintaining high levels of spiritual well-being. Even a person who had ceased to communicate coherently often sang every word of a religious song.

Themes that emerged from the 1998 focus group illustrated how it was possible to incorporate religion and spirituality into the experience of AD. Relying upon unsystematic observation in the absence of empirical data, the researchers believed that non-cognitive pathways to spirituality, for example a multi-sensory approach, brought out "religious memory" for those with dementia and provided them with a sense of peace (Stuckey et al. 2002).

During the focus group dialogue, which included clinicians, researchers, and patients, Gregory, a retired minister and a victim of AD, expressed reliance upon God. Gregory said that the Lord had a design that included everything one needed, and one had only to ask. Gregory could call upon religious memory—memory of scripture passages and hymns—whenever he needed them. Stuckey (2002) stated that although it appeared

to others that Gregory had lost the capacity to fully understand what he was saying, his demeanor expressed peacefulness and assurance that everything would be all right.

Post and Whitehouse (1999) believed that during times of disabling injury, rituals, meditations, prayers, and sacred narratives helped mediate hope for the future despite dementia. Post and Whitehouse stated that they had seen many people turn to prayer when diagnosed with AD and asserted that chaplains and clinicians should encourage prayer to help the diagnosed person gain strength in the midst of cognitive decline. People with dementia often responded to their faith through long-remembered rituals that connected them to the present (Post and Whitehouse 1999).

Researchers and clinicians who studied spirituality in dementia concluded that although it was often difficult to help someone with AD remember their religious beliefs and practices, it was possible. Richards (1990) noted that people ordinarily access their spiritual selves in several ways—through emotion, feeling, and intellectual ability—however, the intellect was not required to address spiritual needs. Richards believed that lessons learned early in life could be used to spiritually communicate with the confused elderly. Richards stated that the person with AD often recognized pictures, music, and familiar prayers and Bible passages. Remembrances could be brought forward through the use of touch, poetry, hymns, and liturgies in the forms learned in childhood. If a person changed belief systems, the earliest one learned was usually the one that was recognized. Faith symbols and rituals reached the person at an emotional level and did not depend upon the intellect (Richards 1990).

Everett (1996) observed that a sense of reverence and peace was evoked when people with dementia experienced God. Everett reported that moments of spiritual

awakening in people with AD were unpredictable, but occurred often. Everett further asserted that all people were spiritual beings and all were seeking to meet their spiritual needs. Those spiritual needs did not end with the onset of dementia. The demented needed every opportunity to experience the triggers that led to those special moments of spirituality. Everett explained that caregivers of dementia patients faced the challenge of helping patients tap into their spiritual emotions (Everett 1996).

Snyder's research (2003) showed that people with early stage dementia often expressed fear that they would forget their religious training. In Snyder's study, one woman explained that she was afraid she would forget about God's promises. The woman stated that she hoped friends would help her continue to feel God's comfort by reading Scripture and praying with her (Snyder 2003).

In general, individuals residing in care facilities have been under-served by ministry providers. In one study of thirteen nursing homes, only 20% of residents attended the nine to thirteen worship services held each month (Justice 1991). People with dementia faced the dual challenge of being under-served and being inadequately served by clergy.

Caregivers of people with dementia often mentioned that they had spiritual needs that were not being met. The wife of one AD victim expressed concern over the fact that someone from the church did not regularly come to talk with her husband about spiritual matters or to pray with him. She explained that both she and her husband needed spiritual nourishment (Stuckey 1998).

Stuckey asserted that churches had an opportunity to provide spiritual connectedness to people who were no longer able to express their spiritual selves

independently. According to Stuckey (1998), some churches had begun to recognize that ministry should address spiritual issues in dementia.

In Katsuno's study (2003), only one of twenty-three participants received social support from his or her pastor or other church members. Katsuno concluded that provisions should be made for people with dementia to fulfill religious beliefs and practices. Katsuno also suggested that spiritual care for dementia patients be included in educational programs for health care professionals and religious practitioners.

Bell and Troxel, of the Alzheimer's Association, said that music, the arts, nature, and religious faith, traditions, and rituals could nurture the human spirit. Bell and Troxel wrote that the senses were important to individuals with AD and they responded to the sights and sounds and smells of the world around them (Bell and Troxel 1999).

Post and Whitehouse (1999) believed that spirituality enhanced the quality of life for people with dementia. They insisted that the deterioration of cognitive abilities called for "spiritual reconstruction." It was possible, within the depths of despair, for people with AD to be spiritually enriched. Post and Whitehouse added that assessment measures must be refined and the relationship between AD and spirituality further explored (Post and Whitehouse 1999).

Sometimes sensory and environmental cues helped people with dementia find their way out of the maze of confusion to realize the spiritual. Richards and Seicol (1991) reported that they have often observed that persons remembered the prayers, hymns, and liturgies of their faith, even when they did not know the time of day. They believed that deeply embedded spiritual memory could unlock the connection to the spirit. Symbols were a part of various faith traditions and to the person who found

meaning in faith experiences in the past, a connection to the symbolism remained at some level. A lifetime of thoughts and feelings were locked inside persons with dementia. There were ways to unlock some of those thoughts and feelings, Richards and Seicol asserted, to help the person with AD get in touch with their spirituality through pictures, music, games, familiar prayers, and Bible verses (Richards and Seicol 1991).

According to continuity theory, people developed habits, preferences, and other characteristics that became part of their personalities and were maintained by them if at all possible (Moberg 2001). Spirituality or religious beliefs were an integral part of one's preferences, personality, and lifestyle that should and could be maintained even in dementia.

Ellor declared that when Alzheimer's disease impaired memories of the past, it was often presumed that all relationships with the past and with fellow human beings were also impaired. Ellor said that if we examined this presumption from the perspective of a relationship with God, the cognitive impairment was seen as less important because although the impaired individual has forgotten, God has not forgotten. Ellor asserted that most theologians believed that the person with AD was not separated from his or her soul and was a person with the potential to be in relationship with God until the end of life (Ellor 1997).

Swinton (1997), a psychiatric chaplain, also rejected the notion that people with cognitive dysfunction were unable to experience a relationship with God. Swinton stated several reasons why he believed as he did. He asserted that divine grace revealed that we were all dependent beings, and knowledge alone did not assure salvation. He suggested that spirituality had as much to do with feeling as with thinking.

Koenig, assistant professor of psychiatry and of internal medicine and director of the Program on Religion, Aging, and Health in the Center for Aging at Duke University Medical Center, researched and wrote about the relationship between religion and mental health for ten years. Koenig argued that the attitude that persons with dementia received no benefit from spiritual care must change because people with dementia had many spiritual needs which varied according to the stage of the disease process. In all but the final stages, Koenig asserted, dementia patients sang or listened to hymns and experienced a wide range of emotions during worship (Koenig 1994).

Use of Montessori-style Methods to Guide Religious Programming.

The Montessori approach to education was developed to teach cognitive, social, and functional skills to children. Medical doctor, Maria Montessori, circa 1900, developed a method of teaching mentally disabled children. Montessori was so successful that children who were considered uneducable were able, after two years in her school, to pass the same examinations taken by normal children.

Montessori's methods included the use of real life, aesthetically pleasing materials. Montessori methods advocated that tasks progress from the very simple to the complex and Montessori methods included the use of many sense modalities—sight, hearing, touch, taste, and smell. In the Montessori methods, the child was given latitude to follow his or her own interests. The leader allowed for the work of the "inner guide" and was cautioned not to over-direct (Montessori Website 2003).

Some of the tenets of Montessori's work with children were transferred to work with people with AD. After an initial pilot study, Cameron Camp of the Menorah Park Center for Senior Living received funding for a three-year study of the use of Montessori

methods of activities in advanced dementia units (Camp 2001). A Montessori consultant helped the staff develop meaningful activities using the Montessori approach. Camp stated that an increase in active involvement of their clients was observed after only a short time. Camp's work continues, and further objective data were being gathered by Camp and his associates. Camp stated that a good Montessori school and a good dementia care facility both stressed goals that promoted self-esteem and attainment of the highest level of functioning possible. He explained that Montessori programming called for breaking tasks down into the simplest steps and guiding residents through tasks a little at a time, thus uncovering their strengths (Bruck 2001).

Camp repeatedly reminded those who worked with Alzheimer's patients that they were people first—people who had varying personalities, needs, and interests. He insisted that the confused elderly should be allowed to engage in the activities that held the most meaning for them (Camp 2003).

Orsulic-Jeras et al. stated that there was little activity programming specifically designed for dementia patients in long-term care. Individuals with AD found it difficult to fully participate in large-group activities. In a recent study, sixteen residents of long-term care who had dementia showed significantly more constructive engagement, less passive engagement, and more pleasure while participating in Montessori-based programming as compared with the regularly scheduled activity programming (Orsulic-Jeras et al. 2000).

The following list summarizes several of Montessori's general principles that guided this research project. The application of the principles that were used in this study to the spiritual enrichment of AD patients is detailed in chapter 3.

1. The use of real life, aesthetically pleasing materials
2. The importance of manipulative materials
3. The use of concrete materials and materials using many sense modalities
4. Progress from the simple to the complex and from the concrete to the abstract
5. Assurance that participants had the capability to manipulate materials and understand what was required of them (these precautions minimize the risk of failure and maximize the chance of success)
6. A realistic pace (The presenter should match his speed of movement to the speed of the participants when presenting activities, typically using slow, deliberate movements)
7. Use of materials and activities that were self-correcting
8. Adaptation of the environment to the needs of the participant

The inclination to participate in activities that promote one's spiritual belief and practice, especially those practices learned in childhood, was important to many aging adults. Since Alzheimer's patients were most likely to retain overall preferences and knowledge acquired at an early age and frequently forgot more newly acquired information, childhood spiritual interest would undoubtedly be maintained with the onset of dementia.

Contributions from Non-academic Sources

In this research, many ideas were gathered from practitioners who were not versed in Montessori methods but whose work had some degree of consistency with Montessori principles. Non-academic sources also provided useful information for

working with people with dementia. Those methodologies greatly enriched this study of spirituality in dementia. Information gleaned from non-academic sources has been detailed below.

Quality of life was associated with having continuing access to activities and relationships that had been important to an individual. For most people, if spirituality held significance early in their lifetime, it did not cease to be important in later life. Cognitively based religious programming did not easily break through the confusion that comes with dementia, particularly in the mid-to-late stages of the disease. Alternative methods were needed to assist victims of Alzheimer's disease to access their faith. Although literature on spirituality in dementia had steadily increased for several years, little empirical research had been published. An exploration of anecdotal reports of methods that were employed by researchers, pastors, and gerontologists follows.

David Wentroble (1999) was asked to provide pastoral services to people with AD. Wentroble asserted that pastoral care helped the person with dementia hold onto the important aspects of his or her faith and helped the individual maintain a spiritual base from which to draw strength. Wentroble found, however, that programs that worked in other nursing home units, did not work on the dementia units.

Wentroble discovered that demented individuals needed to stimulate the senses through smell, taste, touch, sight, and hearing. His small worship groups were enhanced by the use of religious objects in reminiscence packets. Wentroble provided different packets for different faiths. The protestant packet included a Bible, a cross, a "Companion of Prayer for Daily Living," a traditional picture of Jesus, and scripture and prayer cards.

Witherell (1999) met with ten to twenty AD participants twice a week for one-half hour. Witherell began each session by introducing himself and explaining that they were gathered together for a time of singing, prayer, and story—a sort of church time. Witherell reported that when he entered the room with the ball, a bag of stuffed lambs, and his robes, many residents appeared to remember what was about to take place.

Witherell's sessions began with a ball-toss with an inflated world globe and the singing of "He's got the whole world in his hands." Witherell asked residents if they knew who they were singing about in the song. He progressed through "Jesus Loves Me," and "Jesus Loves the Little Children," and led Christmas carols during Christmas or Advent. Witherell then passed out the stuffed sheep and asked the residents to help him by holding the sheep. Witherell began the 23rd Psalm by saying, "This is something you probably have heard before." He paused occasionally to see if anyone was speaking along.

Witherell explained to the residents that the sheep were reminders that God loved us as a shepherd loved his sheep. He then gave a brief meditation, utilizing an object or picture, sometimes talking about God as our "Rock" and asking people what a rock is like, then asking if God was like that. Witherell often asked residents to echo him in leading an antiphonal Psalm, the 150th. He and a helper circulated through the room during the entire service, moving people's arms along with the rhythm of the music. He asked if they knew what prayer was and what the most familiar prayer was—The Lord's Prayer—then they closed with "Amazing Grace" and shook hands with everyone. From time to time Witherell held a communion service (Witherell 1999).

Zgola (1987) stated that despite deficits, people with AD retained some important abilities and strengths. For example, habitual skills, ones that had been learned, practiced, and were automatic, were often maintained for a long time. Primary motor functions such as strength, dexterity, and muscular control were usually retained, and clients could perform a variety of fairly demanding tasks if each step was pointed out, instructions were precise, and perceptual problems were compensated for. Primary sensory function was generally unimpaired as well.

Zgola asserted that a person with AD found pleasure or was repulsed by what he/she saw, heard, touched, smelled, and tasted. He added that individuals with dementia might not be able to interpret complex visual stimuli, but usually derived pleasure from looking at pictures and observing movement and color. Music and other environmental sounds enriched the sensory experience. Zgola noted that rhythm seemed to be retained for a long time. It was essential, however, to guard against sensory overload. The person with AD, said Zgola, had a limited capacity to process a lot of stimulation. Sensory experiences should be kept simple and direct (Zgola 1987).

Lisa Gwyther (1995) observed that symbols of faith elicited responses from those with religious backgrounds. Gwyther stated that their emotions continued to work when they could not think cognitively. The symbol of the cross, a Star of David, or a clerical collar elicited emotions, as did touching a Bible, prayer book, or rosary.

Thomas St. James O'Connor, a Canadian pastor, was frustrated by attempts to talk about God to people who had dementia until he began utilizing religious objects in his ministry. O'Connor was astonished at the response he received when he donned a Roman collar instead of his usual suit and nametag and when he shared the Bible, Holy

cards with Bible scenes, hymns on a tape recorder, a stuffed lamb, and traditional prayers. He concluded that more research was needed in this area (O'Connor 1992).

Koenig (1994) made the following suggestions for working with people who have dementia:

1. Know as much as possible about the person's religious background.
2. Look like a chaplain—wear a collar even if not from a liturgical background.
3. Approach the patient using a conversational tone, and consider hearing/visual impairments.
4. Prayer should be short, simple, supportive, positive, and familiar.
5. Recite familiar scripture passages with patients, and keep them short.
6. Visual cues are communication tools—the rosary, a cross.
7. Singing/whistling hymns gets their attention—one should get in their face and prompt them.
8. Weekly communion was important to those accustomed to receiving it.

Ellor (1997) gave advice for interaction with a person with AD. He recommended first gaining their attention because dementia sufferers were easily distracted and might not recognize that someone was attempting to talk with them. Standing or sitting at the same level helped, as did eye contact. Ellor recommended speaking to people with dementia the way you would want to be spoken to. Dementia sufferers were often aware of other people's feelings, and although they might not be able to process the implications of feelings or behavior in other people, they reacted to them. Requests for a person with AD to act should be simple and made one step at a time.

People with dementia, Ellor advised, must be treated with dignity. Finding tasks that they could continue to do allowed them to feel needed and built self-esteem.

Ellor (1997) believed spiritual needs were often neglected in those with AD because dementia victims were not able to express faith needs. In more advanced stages of the disease traditional worship services were often not meaningful, and people with dementia were potentially disruptive during traditional services. Beyond adapting traditional rituals, said Ellor, creative new rituals that were consistent with the impaired person's religious beliefs could be developed.

Ellor stated that the breakdown of cognitive ability made it difficult, but not impossible, to reach out to the spiritual aspects of the person with dementia. Instead of emphasizing cognitive aspects of worship, the pastoral counselor might emphasize the affective and behavioral aspects of his or her ministry. Music, poetry, repetitive activities, and human interaction were all important aspects of this type of work (Ellor 1997).

Dowling (1995) reported that a good activity program restored a sense of purpose, identity, and control, enabled old roles, and made familiar tasks do-able. Activities were a way to help the impaired person feel good about him or herself. Dowling said that the structured activities that worked with folks who have dementia shared two sets of characteristics: they were familiar and they allowed people to feel successful. "I need your help" was a motivating phrase. Activities should challenge, but not frustrate. It was better not to say "good try" because it implied failure. A "Thank you" or "Okay, great" was more encouraging. The idea of independent activity was usually counterproductive

with dementia patients. If left alone to their own pursuits, they often became nervous, angry, or terrified.

Dowling recommended that religious services be simple, short on sermons, heavy on hymns and scriptures. Prayers should be familiar and brief. Hymns should be old standards. Dowling believed that some of the significance of religion in dementia had to do with non-verbal aspects. Visual symbols were powerful: a cross, a Star of David, candles, a clerical collar, and a yarmulke. Rote gestures and responses learned in childhood and more or less rehearsed often over the years, tended to remain long into the disease: Making the sign of the cross, accepting the host in Communion, obeying the command, "Let us pray," repeating an "amen," and singing "amen" at the end of a hymn. Familiar responses such as repeating "Glory be to God" and reciting the Lord's Prayer had an emotional effect on participants (Dowling 1995).

Everett (1996) argued that long services, involved sermons, and unfamiliar prayers did not provide an experience of true worship for people with cognitive impairment. Those with mild dementia were receptive to brief reflections using symbols, images, or object lessons. Everett said that people at every level of impairment seemed to be affected by symbols and rituals, music, and actions that conveyed the presence of God. She stated that the power of the Spirit of God should not be underestimated. Faith memory was sometimes prompted through hymns, prayer, scripture, symbols, and nature. Everett used a tape recording of water sounds to release in residents an awareness of the joy of life. She believed that snowballs, animals, and autumn leaves all speak deeply to the cognitively impaired. Everett stated that program planners should arrange as many

opportunities as possible for the person with dementia to experience nature through tactile experiences (Everett 1996).

Everett noted that worship should be a multi-sensory experience using touch, music, even nature as pathways to connect with someone with dementia. She explained that a multi-sensory approach to worship brought out "religious memory," providing a sense of peace, and Everett related that oftentimes a person who was deep into AD and had ceased to communicate coherently would sing every word of an old hymn.

Everett suggested several things in planning spiritual care for people with dementia. She asserted that in moments of fear and discouragement, another's presence, prayers and blessings were tangible evidence of God's love. Love, respect, and recognition of each person's unique value were expressions of Christian love. People with dementia remained very sensitive to the mood around them—they may not understand the reason for moods, but they were often accurate about them. Individuals with AD also understood the emotional content of facial expressions. Everett said that love was conveyed by touch; physical contact said to the dementia sufferer that she was treasured and not untouchable. Pictures and music helped people with dementia learn. Familiar hymns made an unfamiliar environment feel safer and less threatening. When Everett sang 'He's got the whole world in His hands" and inserted the residents' names into the song, they became much more attentive and alert (Everett 1996).

The Cleveland community dialogue elicited the following guidelines for offering spiritual support to persons with AD (Stuckey et al. 2002):

1. Include traditional hymns and sacred readings in the worship experience; avoid long homilies or sermons and unfamiliar songs or lyrics.

2. Include touch in the worship experience or as part of communication.
3. Integrate those with AD into the worship experience to the greatest extent possible; do not isolate them in the back of the place of worship or make them feel unwelcome because of their behavior.
4. A minister, rabbi, or other clergy should dress in a way that is expected of clergy from the religious background of the demented person.
5. Include nature as part of a worship experience; for example, take walks or listen to the sounds of the outdoors.
6. Teach clergy and laity how best to interact with persons with AD.
7. Engage persons with AD in conversation even if they cannot visibly reciprocate.
8. Learn about and be sensitive to the specific religious tradition of those with AD.
9. Maintain regular contact through frequent follow-up visits, particularly if the individual had limited opportunities for interaction with others.

Stuckey reported that the senses were an important tool in worship. Stuckey said that many families and nursing home staff had recalled to him incidents of persons with AD spontaneously singing the words of a religious hymn or participating in a sacred ritual after years of silence.

Stuckey claimed that spiritual care and support of persons with AD were as important as physical or emotional care and support. Stuckey stated that the people working with individuals with AD should be encouraged to use whatever means possible

(e.g., the senses, reading, or music) to maintain connection to the spirit of persons with AD regardless of their stage of the disease (Stuckey, et al. 2002).

Ellor, Stettner, and Spath (1987) asserted that worship did not need to be an exclusively intellectual experience, but could become an emotional and sensory experience. Ellor et al. gave an example of a worship service that was held in predominately Methodist nursing homes with dementia patients. The service was organized around four basic elements that were familiar to older persons (1) favorite hymns, (2) favorite Bible verses, (3) patterned liturgical responses—familiar statements of praise and prayer responses, and (4) well-known prayer like the Lord's Prayer.

Ellor et al. found that the content of worship materials was important. Ellor stated that material should be upbeat and positive, suggesting reassurance, hope, and love because many confused seniors took only a phrase or two from a hymn or prayer and repeated it over and over throughout the day. Since people with dementia had a limited ability to understand worship material, it appeared that an emphasis on love and forgiveness was more beneficial than other aspects. Ellor agreed with previously mentioned authors when he stated that all directives should be broken down into simple steps, thus reducing frustration.

Ellor and his cohorts found that books, especially those with small print, were not useful and only the leaders used them. A blackboard or a large sheet of newsprint was more useful. Hand gestures and other motions were effective, such as raising the arms when they said "Praise the Lord." Two Old Testament and two New Testament readings were chosen each Sunday, and older persons were most familiar with the King James Version. Hymns that had a refrain generally worked best, such as "How Great Thou

Art." First verses of hymns were the only ones likely to be remembered (Ellor, et al. 1987).

Kirkland, a music therapist, and McIlveen, a pastor, devised a program for eight to twelve people with dementia, called Full Circle, to address spiritual needs (Kirkland and McIlveen 1999). Kirkland and McIlveen developed thematic programs for discussion. They helped the group sit in a circle in order to come "full circle with their past and with their faith." The full-circle group met in a lovely room for forty-five minutes to an hour once a week.

Each session was begun with the singing of the same song—“This is the day"—and each session ended with the same song—“God be with you ‘til we meet again." This routine provided familiarity and structure.

A different theme was explored at each session. The themes were based on topics that the residents could grasp and explore—things that were tactile, concrete, multi-sensory, and appropriate to the needs of the group participants. Poems, quotations, discussion questions, sensory cues—smell, sight, touch, sound—were used; and both the past and the present of participants was honored. An example of one sensory topic was hands: shaking hands, reminiscing about use of hands—sewing, baking, building, scrubbing, holding—and exploration of gestures—hands folded in prayer, a finger pointed at someone, and waving. Songs and hymns about hands were sung—"He's got the whole world in his hands" and “Lay your hands gently upon us". Other themes that were suggested included: Sensory (hands, touch, sigh), life review (change, dreams and aspirations, friendship, work), spiritual (heaven, healing, peace, and prayer), feelings

(depression, forgiveness, sorrow or grief, joy), and special occasions (Easter, Christmas, Veterans' day, or Advent.)

Kirkland and McIlveen insisted that people with dementia had within them profound potential to change and learn. Although AD victims often did not remember what was talked about five minutes ago, these individuals could experience the feelings of the moment. After experiencing the Full Circle groups, the authors noticed significant changes in behaviors. There was less weepiness, fewer outbursts, and decreased wandering. Kirkland and McIlveen believed that the Full Circle residents found support and the presence of God, and contended that this support was a basic need that added to the quality of life of the institutionalized elderly.

Kirkland believed that spirituality was a term that meant many things to many people. For dementia care and for the elderly, there were several elements and benefits to spirituality that were of vital importance to quality care. Kirkland asserted that it helped older, demented individuals make sense of their situation and find meaning in their days and their lives. Kirkland also claimed that it helped confused elderly accept their circumstances and know that they were loved and were capable of giving love.

Todd (2003), a nursing home administrator and consultant in Claremont, California, reported that since Alzheimer's disease destroyed the part of the brain that enabled people to understand language and to communicate, frustration would be a part of the person's life as communication skills declined. R-E-S-P-E-C-T was Todd's acronym for *reassure, environment, specify, prepare, encourage, check yourself, and thank*. Todd explained methods of communicating with people with AD. Todd's explanations are summarized below.

1. *Reassure.* Never approach someone with AD suddenly. Always speak in a soft tone, address him/her by name, and introduce yourself as often as needed. Help focus attention by maintaining eye contact and gently touching a hand or arm when needed. Never tower over or talk from behind the person, get down to his/her level.
2. *Environment.* Someone with AD could be hypersensitive to disruption and to the environment around him/her. When trying to communicate, there should be as little distraction as possible. Background noise, too much or too little light, temperature, all affect the person's ability to concentrate. Agitation is often the result of something in the environment that overwhelms or confuses the person with AD. Something as seemingly unimportant as a beam of sunlight falling across the line of sight of an individual with dementia could be distracting. If a reason for agitation is not found, simply going to another room sometimes helps.
3. *Specify.* Stay with the concrete. Complex themes and topics add to residents' confusion. Use small words and sentences as well as nouns and proper names. Pronouns are confusing. Ask "yes" or "no" questions, never multiple-choice. Multi-task situations should be communicated one step at a time with ample time for the person to complete that step. If the resident does not understand what is being said, it should be repeated exactly the way it was first presented.
4. *Prepare.* Prepare for activities ahead of time, whether changing clothes or getting ready to eat. Lay the materials out in a logical sequence and give

one-step instructions. Accommodate the person's patterns and preferences that have been with him/her for a lifetime. Resistance, anger or combativeness signal that something is wrong, but the person with AD is unable to communicate what it is. Anticipate needs of hunger, thirst, pain, or need to go to the bathroom.

5. *Encourage:* Don't make a confused person feel pressured to communicate. Smile often, give undivided attention. If he or she loses the train of thought mid-way, repeat the last few words. He may have trouble finding the right words and may substitute words that sound similar or have a similar meaning. Try to guess what he wants to say, and if you guess wrong, try again. If communication is not working, or he seems overwhelmed, tell him you'll come back in a few minutes and that you look forward to seeing him again. Try ten or fifteen minutes later.
6. *Check yourself:* It is critical to remain calm and soothing in order to reduce the confusion of the person with AD. They are often very sensitive to the emotional climate in their surroundings. Ask, offer, suggest, and encourage the resident's participation in decision-making. Always be kind, respectful, and positive with the person with AD. They are sensitive to body language and to being rushed, and they will notice rude and demeaning behavior.
7. *Thank:* Every individual responds better when they are treated with respect. Developing rapport is the key to gaining the trust of people with dementia and improving communication, which will lead to more

cooperation. Thank the person for spending time with you no matter how the communication goes.

Chapter Summary

Dementia was a term used to describe a decline in cognition caused by the loss of functioning of brain cells. Because the number of elderly was growing, the number of people with dementia was growing.

Activities were viewed as a vital part of life whether one has dementia or not, and spiritual growth was one of the important activity areas. The literature recognized that for most people religious faith and practice became increasingly important with age. There was no evidence or reason to believe that people lost their need for spirituality when they became demented. As this chapter explained, many people with dementia had shown the desire and the need to maintain spirituality.

Camp's work demonstrated that Montessori methods could not only help children, but could also be used to help people with Alzheimer's learn and grow. The present research focused on a Montessori-style use of multi-sensory materials to enhance people's spiritual memory.

CHAPTER 3

RESEARCH STRATEGY

This research examined and compared three forms of ministry visitation on the affective experience of individuals with mid-stage dementia. Traditional Ministry Visitation (TMV) was compared with two variations of Multi-sensory Ministry Visitation (MMV). Chapter 3 states the hypotheses and operational definitions, describes assumptions and limitations of the research, and details all aspects of research design, research procedures, methodology, and data analysis.

Hypotheses

This inquiry sought to determine which of three alternative forms of visitation most effectively engaged the participants with a ministry experience by (1) measuring the number of seconds of pleasure displayed during each of the ten minute treatments and (2) measuring the alertness of the participants during each ten minute treatment. Hypothesis 1 addressed the first issue. Hypothesis 2 addressed the second issue.

Null Hypotheses

Hypothesis 1 (H_o1): There was no significant difference between the effects of Traditional Ministry Visitation (TMV), Multi-sensory Ministry Visitation-Book (MMV-Book), and Multi-sensory Ministry Visitation-Object (MMV-Objects) on the observable affective experience of women with mid-stage dementia as measured by the Observed Emotion Rating Scale (OERS).

Hypothesis 2 (H_o2): There was no significant difference between the effects of TMV, MMV-Book, and MMV-Objects on the alertness of women with dementia.

Operational Definitions

Mid-stage Dementia: Dementia was the umbrella term for several diseases that resulted in the loss of cognitive abilities. In this study, the mid-stage of dementia was defined as having a score of ten to nineteen on the Mini-Mental State Exam (MMSE). The terms Alzheimer's disease (AD) and dementia were used interchangeably in this study.

MMV-Book: Multi-sensory ministry visitation using the Multi-sensory Visitation Book developed by the author.

MMV-Objects: Multi-sensory ministry visitation using a multi-sensory basket of objects.

Observable Affective Experience: The dominant emotional condition (pleasure, interest, contentment, sadness, anxiety, and anger) as measured by the Observed Emotion Rating Scale (Lawton et al. 1999)

TMV: Traditional ministry visitation: Visitation that relied on cognitively-based conversation, Bible study, and prayer.

MMSE: Mini-Mental State Exam. A standardized method of identifying whether individuals with dementia are in the early, middle, or late stage of the disease.

Assumptions

Although individual differences existed among people who suffered from dementia, there was similarity in the manifestation of the various kinds of dementia. People with dementia displayed similar signs of cognitive decline, which included confusion, loss of short-term memory, inability to perform routine tasks, problems with

reasoning, disorientation, difficulty learning, and loss of language skills. People with dementia often experienced changes in personality and/or exhibited behavioral problems as well. The symptomatology of dementia within this research population was consistent with people in the larger population. Applicability of this data may provide similar results when applied to the larger population.

Female participants in this study included only those with mid-stage dementia according to their scores on the MMSE (Folstein et al 1975). It was assumed that individuals who scored ten to nineteen on the MMSE had similar cognitive abilities.

The capacity for spiritual experience remained even when recent memory and cognitive skills diminished. Research support for this assertion has been reviewed in chapter 2.

It was assumed that data gathered were reliable and valid. The processes for gathering data were described in detail below.

It was assumed that the group of participants was sufficiently homogenous in their historic exposure to and interest in the Christian faith. Only individuals whose biographic data indicated that they were of the Christian faith were included in the study.

It was assumed that the content of the three treatments was similar enough that it did not influence the outcome. It was further assumed that, although the content of each treatment was on the same topic, redundancy at intervals of one week was not objectionable to the participants.

Limitations

A limitation of this study was that all participants were women. It could not be assumed that findings of the study would generalize to males.

Another limitation was that all participants were of the Christian faith. Although it was assumed that people of other faith traditions would benefit from multi-sensory ministry as well, the researcher kept the research within the parameters of the Christian faith.

The number of participants available for the study was a limitation. Four facilities in the Chattanooga area were represented in this research. Not all individuals who met the specifications for inclusion in the study, according to MMSE scores and a background of Christian faith and practice, were able to participate in the research due to an inability to obtain conservators' signatures on release forms.

Research Methodology

The Latin Square Design was used to neutralize the effect of order of treatments upon the outcome. The design articulated with the repeated measures design so that the effects of the order of treatment as well as the treatments themselves could be analyzed. All experimental subgroups received the same three treatments. The only difference between subgroups was the order of presentation of the treatments. There were an equal number of participants (eight) in each subgroup (see table 1 for sequence of presentation of treatments).

Three Treatments

Traditional Ministry Visitation (TMV) emulated the pattern of activity frequently employed by clergy or other church-based visitors. Thus, TMV was considered the baseline treatment in this research. In TMV, the visitor established rapport by conversing for several minutes, a brief Bible lesson was then offered, and this was followed by The

Lord's Prayer. The session closed with a personal prayer for the individual (see appendix 2).

The Multi-sensory Ministry Visitation-Book (MMV-Book) began with a brief conversation to establish rapport with the participant. Then, a Bible lesson using a multi-sensory book, developed by the researcher, was presented. The content of the book was similar to the content of the Bible lesson presented in the Traditional Ministry Visitation, but included sensory interaction. For example, on the page that showed the kings bowing down to worship baby Jesus there were replicas of ancient gold coins glued to the page. There was also a plastic-encased card that pictured a bottle of perfume and to which drops of frankincense and myrrh were applied. The card slid out from the plastic, releasing the scent. The lesson ended with a recitation of The Lord's Prayer (see appendix 3).

The second experimental treatment, MMV-Objects, began with a brief conversation to establish rapport. Objects that could be handled by the participants were used to engage them with the Bible lesson. Each object was related to the content of the lesson and stimulated one or more of the participant's senses. Objects were carried in a bright basket and included the replica gold coins mentioned above, an eight-inch wooden cross that could be held, a hand-sized realistic-looking plush sheep, a large imitation pearl, a bunch of wheat stalks, and a bottle of frankincense. After the Bible lesson, similar in content to that which was used in treatments TMV and MMV-Book, the visit was closed with The Lord's Prayer (see appendix 4).

Data Collection

Criteria for Participants

Individuals meeting the following six criteria were identified:

1. They had been identified by family members as lifelong Christian adherents.
2. They were female.
3. They scored ten to nineteen on the MMSE.
4. They were deemed by facility nurse or social worker to be physically, behaviorally, and psychologically able to participate in the study.
5. They consented to help with the study. (If there was the slightest indication of discomfort with the lesson or the presenter, the lesson would be discontinued)
6. Consent could be obtained by their next-of-kin or conservator.

Selection of Participants

Admission to long-term care (LTC) or assisted living facilities occurred when patients had deficits in Activities of Daily Living (ADL's) that required the guidance or support of other persons. Participants for the research were recruited from two LTC facilities, one with 120 beds, one with 80 beds, an assisted living facility with 130 beds, and a secured dementia unit within an assisted living community with 45 beds.

Criteria for participation in this study included having a diagnosis of mid-stage dementia and being a resident of a long-term care or assisted living facility. Age was not a consideration in the study, but all participants were sixty-five to eighty-five years of age. It was believed that the population of the four facilities to which the researcher had access was characteristic of female residents with mid-stage dementia who resided in other local facilities that serve individuals with dementia.

Because consent forms were signed and obtained over the course of many weeks, participants were assigned to groups in the Latin Square as consents became available. Margaret W.'s form was returned on April 5th, so she was assigned to Group A, Linnie S.'s consent form arrived on April 7th, and was assigned to Group B, and so forth. When several arrived simultaneously, the participant's names were drawn at random and assigned to the group next in line.

Identifying Participants with Mid-stage Dementia

The Mini-Mental State Exam was used to identify women in mid-stage dementia. The MMSE was a brief quantitative measure of cognitive status of adults. The standardized thirty-five item exam assessed orientation, immediate and short-term recall, attention, delayed verbal recall, naming of objects, three-stage commands, reading, and writing. The instrument demonstrated validity and reliability (Folstein et al 1975).

The MMSE had been administered by trained professionals in the facilities that agreed to participate in the research prior to the commencement of the study. The maximum possible score was thirty, and the minimum was zero. The moderate or mid-stage score was ten to nineteen. Individuals who fell in the mid-range of dementia according to their scores on the MMSE were identified for inclusion in this study.

The Latin Square

When participants were exposed to repeated measures, the order of exposure was potentially a confounding effect. The possibility was neutralized by randomly assigning participants to groups according to the Latin Square process, so that an equal number of participants were presented with each of the three permutations of the three treatments. The Latin Square design was basically equivalent to the repeated measures design except

that the effects of the order of treatment presentation could also be analyzed (Bruning and Kintz 1968).

The three Latin Square groups were referred to as groups A, B, and C. The sequence of treatment presentation was shown in table 1.

Table 1. Sequence of Treatment Presentation

	TMV	MMV-Book	MMV-Obj.
Group A	First	Second	Third
Group B	Third	First	Second
Group C	Second	Third	First

Observed Emotion Rating Scale

Lawton, Van Haitsma, and Perkinson (2000) observed that emotion was evidenced at several levels—neurological, neurophysiological, behavioral, and subjective. Emotion did not exist only as subjectively recognized feelings. The face, as an indicator of emotion, had been repeatedly validated across cultures (Ekman, Friesen, O'Sullivan, and Chen 1987). Voice quality and body position and movement were also shown to give cues to people's emotional states (Caporael et al. 1983; DeLong 1970).

The Observed Emotion Rating Scale (OERS) was developed to measure the full range of emotions in residents with dementia in long-term care settings (Lawton et al. 1999). The OERS measured the frequency and duration of six emotions: pleasure, interest, contentment, sadness, anxiety, and anger by direct observation of facial expression, body movement, and other cues that do not depend on self-report. The scale was first known as Philadelphia Geriatric Center Affect Rating Scale. The OERS was a standardized and validated instrument first used among 253 demented and forty-three non-demented residents at the Philadelphia Geriatric Center (Lawton, Van Haitsma, and

Klapper 1996). It was used by well-known researcher, Cameron Camp, to assess individuals' reactions to Montessori-based activities (Camp et al. 2000). Further information appears in appendix 8.

In this study, measures of pleasure and alertness were the only categories that were measured by the OERS as it was pre-determined to protect the participants from adverse reactions by discontinuing the treatment if there were displays of anger, anxiety, fear, or grief.

Training Observers

Three volunteers were selected as observers for the study on the basis of maturity (all were over forty years of age), experience with the aged population, and availability. One observer was a licensed social worker who currently worked with dementia patients, the other two were engaged in ministry with the elderly. One of the ministry volunteers had a parent who died from Alzheimer's.

Data for the OERS were acquired through observation of participants by the volunteer observers. The three observers were carefully trained to use the OERS with the aid of a twenty-five minute training video developed by the team who created the scale. The observers were trained in precise methods of gathering quantifiable data. During training, all three observers correctly identified displays of pleasure and displays of alertness. Following the training, the Effect of Observers was analyzed using the Scheffé Multiple-Comparisons Test (see table 9). The data gathered by the three raters were not significantly different, indicating that the results of the study were not influenced by the variations of perception within the raters.

Observers used a watch with a second hand to measure the number of seconds of observed pleasure, defined for this study as smiles or laughter only, and alertness, defined as the number of seconds participant's eyes followed the presenter or the objects being presented. Although the scale was developed in order to measure fear, anger, and sadness as well, it was pre-determined that if the participants of the study displayed any discomfort, the sessions would be discontinued. Only pleasure and alertness were measured.

Necessary Approvals and Permissions

Permission was sought from facility administrators before the research took place. Out of seven facilities that were approached, six agreed to assist with the project. Facility secretaries sent letters explaining the research along with consent forms to families whose resident met the required specifications. The research began after the research had been explained to the family, to the person with dementia, and after written authorization was obtained from family and administrators (see appendix 6).

Methodology of Treatment

Materials Used During the Visitations

Although the interest of this research was upon style of ministry, not content, because content was a potentially confounding variable, its influence was reduced by introducing the same content into each of the three treatments. The materials used were crafted with that in mind. Many Montessori principles, especially the multi-sensory aspects, were incorporated into the MMV treatments. The list below reiterates several Montessori principles that guided this research. The application of Montessori principles,

as they are used for spiritual enrichment in this research, is also explained. Italics signify the Montessori principle.

The use of real life materials that are aesthetically pleasing: In religious programming for people with AD, symbols are important. A cross helps people with dementia understand the purpose of the visit. Bright colors attract attention. Realistic pictures are understood by the person with dementia, whereas abstract or cartoon-like pictures are difficult for them to decipher. Perfume stimulates the sense of smell. Real life, aesthetically pleasing elements were included in the MMV treatments.

The importance of manipulative materials: In the treatment that utilized a visitation basket (MMV-Basket), a hand-size wooden cross, a realistic-looking plush lamb, bright gold coins, and a large imitation pearl were placed. The basket additionally contained a bouquet of wheat stalks, a piece of richly scented cedar, and a bottle of highly fragrant frankincense and myrrh essential oil.

*The use of concrete materials and materials using many sense modalities***:** Camp (2001) demonstrated that just as Montessori's children learned better when they used materials that stimulated the senses, people with dementia also learned better with those aids. In this research the senses of sight, hearing, touch, and smell were tapped.

Progress from the simple to the complex and from the concrete to the abstract: In the treatments utilizing the MMV-Book and the MMV-Basket, the person with dementia was able to touch pictures and objects, turn pages, read familiar Bible verses from easily read pages using forty-eight point sans serif font. The concrete pictures and touchable objects could be translated into the more abstract concepts of God's love and care.

Ensure that participants have the capability to manipulate materials and understand what was required of them. It was important to minimize the risk of failure and maximize the chance of success. During the treatments, the participants were invited to touch, hold, turn pages, and read. The presenter turned pages or read aloud when the participant seemed unwilling or unable to do so. It was possible for the confused elder to perceive the research materials and the visit as a mere pleasant distraction, or the visit could have enabled her to feel a sense of God's presence.

Adapt the environment to the needs of the participant. If the participant was cold, needed to go to the bathroom, or the environment was too distracting, it was important to meet the immediate need of the individual before proceeding. The treatments were performed on the participant's timetable, not the presenter's.

Traditional Ministry Visitation

The Traditional Ministry Visitation was carefully planned and outlined to ensure similarity of content among participants. The content of the lesson was essentially the same as in the other two treatments, but was delivered extemporaneously and without tangible illustrative objects or supplemental materials such as pictures. The teaching plan is detailed in appendix 2.

Multi-Sensory Ministry Visitation-Book

The book, *The Life of Jesus*, was designed specifically for use in this research. The book was 8½ x 11 inches, with twenty-six pages printed on index stock, and with a plastic comb binding. As the book was opened, the left-hand page had a limited amount of easily understood text printed in forty-eight point sans-serif type. The text summarized one teaching point relevant to a full-page picture on the right-hand panel.

The content of the book offered highlights from the life of Jesus. The pictures were realistic in style because persons with dementia perceive photographs and highly representational artwork more readily than they perceive abstract or cartoon-like images. Each picture had some sensory element associated with it: a scrap of sheep's wool to be touched, a thin strip of cedar-scented wood associated with Joseph's carpenter shop to be touched and smelled, and a picture of Jesus teaching the parable of the pearl of great price, with a large imitation pearl on a cord attached to the page. A representation of the book, without the applied tactile materials, which were too bulky to include herein, appears as appendix 3.

Multi-Sensory Ministry Visitation-Objects

The MMV-basket was brightly colored and had a small bunch of colorful flowers attached to the handle. Materials held in the basket included a simple wooden cross about eight inches in height, a bouquet of wheat stalks, a plush, realistic looking lamb, a bottle of frankincense and myrrh perfume, an eight by ten-inch laminated picture of Jesus, familiar to most Christians, a box of imitation gold coins, a large imitation pearl, a richly scented piece of cedar, a five inch by five inch piece of rough sandpaper, and a slightly larger scrap of red satin. Illustrations of the objects are shown below as appendix 4.

Methodology of the Presenters

A description of methods of ministry visitation is presented in the following section. A single presenter conducted each lesson, therefore, content, duration, and style were as uniform as possible from visit to visit. Each ministry visit was approximately thirteen minutes long. Each visitation contained the same lesson content, in the same

sequence. The visits opened with a conversation of two to three minutes to build rapport, continued with the body of a Bible-based lesson, which lasted ten minutes, and closed with a one or two minute prayer. The opening and the closing prayer were not counted on the timed rating scale. Pleasure and alertness were measured only during the ten-minute lesson.

Consistent with Montessori principles, teaching was delivered with an attitude of respect for the individual in as peaceful a setting as possible. Teaching materials were neat and attractive and created to appeal to several of the senses. The TMV presentations were likewise conducted in a manner consistent with Montessori principles, with the obvious exception that multi-sensory materials were not used.

The visitor was congenial and cheerful in demeanor, respectful of the participant's needs and interests, was an attentive listener, yet businesslike in fulfilling the pastoral nature of the opportunity for interaction with the participants about spiritual matters. Instructions for the visitor appear in appendix 5.

Traditional Ministry Visitation

The Traditional Ministry Visitation emulated the typical pastoral visit and had much in common with the content and style of group worship services conducted by clergy or lay volunteers in nursing homes. The delivery of the lesson was essentially didactic; a lecture to an audience of one, with the occasional rhetorical questions and with implied opportunity for dialogue without particular devices that encouraged the asking of questions or the opening of dialogue. Two or three minutes were allowed for greeting. The duration of the lesson portion of the visit was ten minutes. The visit concluded with

a one to two minute recitation of the Lord's Prayer (Mt. 6:9-13), prayer for the person, and goodbye.

Multi-Sensory Ministry Visitation-Book

The uniqueness of the book, *Remembering the Life of Jesus*, was that it was designed for participation by the participant. The visitor engaged the participant in rapport-building conversation for two to three minutes, then "paged through" the book by reading the text, encouraging the participant's use of touch and smell, and by inviting her comments. At times, the participant read aloud or in unison with the visitor. The duration of this portion of the visit was ten minutes. The visit concluded (one to two minutes) with recitation of the Lord's Prayer (Mt. 6:9-13), prayer for the individual, and goodbye.

Multi-Sensory Ministry Visitation-Objects

This strategy was similar to that of MMV-Book. The visitor engaged the participant in rapport-building conversation for two to three minutes, then presented the lesson in dialogic fashion as was done in MMV-B. An object was handed to the participant concurrent with its use in the lesson. The duration of this lesson portion of the visit was ten minutes. The visit concluded with a one to two minutes recitation of the Lord's Prayer (Mt. 6:9-13), prayer for the individual, and goodbye.

Gathering Data

Each set of three sessions was held at approximately the same time of day, either during the morning hours or early afternoon because individuals with dementia were more likely to display agitation as the day wore on. During the sessions, the presenter sat close to the participant, while observers were instructed to sit to the side, out of direct

vision of the participant, but where they could watch the participant's face. At each visit, the presenter introduced herself and the observer, explained that she was studying methods of worship, and asked the subject if she would assist with the project.

After an initial explanation concerning the observer's presence, the observer was instructed not to interact with presenter or participant during the treatment. Using a second-hand watch, the observer timed the number of seconds or minutes the participant displayed pleasure and alertness using the Observed Emotion Rating Scale. After each session, when observer and presenter were alone, a period of debriefing took place to discuss the participant's reactions.

Chapter Summary

This research compared Traditional Ministry Visitation with two variations of Multi-sensory Ministry Visitation on the affective experience of people with dementia. Affect was measured with the aid of the Observed Emotion Rating Scale. The Latin Square Design allowed both the order of treatment and individual treatments to be analyzed.

CHAPTER 4

RESEARCH FINDINGS

The purpose of this study was to compare three forms of ministry visitation upon women with mid-stage dementia. The Traditional Ministry Visitation was compared with two variations of Multi-sensory Ministry Visitation. Two independent variables were measured: observable affective experience—roughly equivalent in this study to pleasure—and alertness during the treatment experience. In chapter 4 the data are reviewed and the statistical analyses of data described.

Data Collection

Data were collected over a period of three months. Twenty-four women with mid-stage dementia were assigned to Group A, B, or C of a Latin Square design. The assignments were made in sequence, in the order of receipt of consent forms. The first treatment for Group A was the Traditional Ministry Visitation (TMV), followed by Multi-sensory Ministry Visit-Book (MMV-Book) and Multi-sensory Ministry Visit-Objects (MMV-Objects). Group B began with MMV-Book, followed by MMV-Objects and TMV. Group C began with MMV-Objects followed by TMV and MMV-Objects. The Latin Square rotation appeared as table 1 in chapter 3. Each participant was visited three times.

Each treatment consisted of a ten-minute Bible lesson. A trained observer sat to the side, out of direct line of vision of the participant, but where she could observe the

participant's face. To minimize possible distracting influence on participants, the same observer was used in each session with a participant. The Observed Emotion Rating Scale was used to record the amount of time a participant displayed pleasure and alertness. Using a watch with a second hand, the observer recorded the number of seconds of observable pleasure, defined as laughing or smiling, during each ten minute session.

The observer also recorded the number of minutes of alertness to the research procedure. Alertness was defined as the amount of observable time, in seconds, that participants were engaged with the presenter or the material as indicated by following either the presenter or the material with their eyes during each ten-minute session.

Compilation of Raw Data

Observed affect (in seconds) and alertness (in seconds) were recorded in separate Microsoft Excel spreadsheets. These data appear below as tables 2 and 3 respectively.

Descriptive Data

Descriptive summary data for observed affect (pleasure) appear as table 4. For TMV, the mean was 63.08 seconds with a standard deviation of 96.31. For MMV-Book, the mean was 325.08 and standard deviation was 201.93. For MMV-Object, the mean was 263.12 and standard deviation was 210.50.

Descriptive summary data for observed alertness appear as table 5. For TMV, the mean was 462.50 seconds with a standard deviation of 162.62. For MMV-Book, the mean was 587.50 and standard deviation was 35.29. For MMV-Object, the mean was 557.50 and standard deviation was 124.46.

Table 2. Raw Data: Observable Affect in Seconds

	Treatment			
Group A	Traditional	Book	Objects	Observer
MW	0	480	600	KG
LG	60	282	534	SH
WS	15	30	30	SH
IC	252	311	330	SH
VM	0	30	0	MK
GS	339	459	296	MK
BB	163	252	298	SH
SS	0	133	90	SH
Group B	Book	Objects	Traditional	Observer
LS	480	300	0	KG
FA	300	15	5	KG
JC	300	59	0	KG
EM	480	480	59	KG
CW	600	354	15	MK
NG	74	119	74	MK
CM	281	99	32	SH
RC	600	300	60	KG
Group C	Objects	Traditional	Book	Observer
EJ	300	0	480	KG
OP	300	234	300	KG
TW	480	0	480	KG
EW	492	0	494	KG
VA	720	176	717	MK
NY	59	15	60	MK
VP	0	15	89	MK
CV	90	0	90	KG

Table 3. Raw Data: Alertness in Seconds

	Treatment			
Group A	Traditional	Book	Objects	Observer
MW	300	600	600	KG
LG	600	600	600	SH
WS	600	600	600	SH
IC	480	600	600	SH
VM	420	600	600	MK
GS	600	600	600	MK
BB	600	480	600	SH
SS	300	600	600	SH
Group B	Book	Objects	Traditional	Observer
LS	600	300	300	KG
FA	600	60	60	KG
JC	600	600	600	KG
EM	600	600	300	KG
CW	600	600	300	MK
NG	600	600	600	MK
CM	540	600	540	SH
RC	600	600	600	KG
Group C	Objects	Traditional	Book	Observer
EJ	600	300	600	KG
OP	480	300	600	KG
TW	600	300	480	KG
EW	600	600	600	KG
VA	540	600	600	MK
NY	600	600	600	MK
VP	600	600	600	MK
CV	600	600	600	KG

The mean score for the Traditional Ministry Visit was lowest of the three treatments and Multi-sensory Ministry Visit-Book highest of the three treatments on both the pleasure and the alertness measures. For TMV, MMV-Objects, and MMV-Book, the means for pleasure were 63.08, 263.12, and 325.08 seconds respectively, and for alertness were 462.50, 557.50, and 587.50 seconds respectively. One would note the obvious point that alertness in response to an interactive event is a prerequisite for pleasure, and the scores reflect that.

Table 4. Descriptive Data: Observed Pleasure in Seconds

Treatment	Mean	Standard Deviation
TMV	63.08	96.31
MMV-Book	325.08	201.93
MMV-Objects	263.12	210.50

Table 5. Descriptive Data: Observed Alertness in Seconds

Treatment	Mean	Standard Deviation
TMV	462.50	162.62
MMV-Book	587.50	35.29
MMV-Objects	557.50	124.46

To test for possible influence resulting from the research design, the raw data were re-sorted by presentation order and by observer. These findings are reported immediately below. Analysis of these data appears later in this chapter merged with analysis using inferential procedures.

The descriptive data for effects of presentation order appear as table 6. Presentations that were given first resulted in a mean value of 266.04 with a standard deviation of 222.42, presentations given second had a mean value of 172.62 with a standard deviation of 166.12, and presentations given third had a mean value of 212.62 with a standard deviation of 277.68.

Table 6. Descriptive Data: Presentation Order

Order	Mean	Standard Deviation
First	266.04	222.42
Second	172.62	166.12
Third	212.62	277.68

The descriptive data for effects of observer appear as table 7. Data are presented here, with analysis deferred to later in the chapter and merged with findings from inferential statistical procedures. Presentations observed by KG, resulted in a mean value of 405.00 with a standard deviation of 184.71, presentations observed by SH had a mean value of 260.00 with a standard deviation of 282.97, and presentations observed by MK had a mean value of 260.00 with a standard deviation of 285.27.

Table 7. Descriptive Data: Observers

Observer	Mean	Standard Deviation
Observer KG	405.00	184.71
Observer SH	260.00	282.97
Observer MK	260.00	285.27

Statistical Data Analyses

Six values were established for each of the twenty-four participants: a rating of pleasure and a rating of alertness for each of the three treatments being tested. Values were in units of one second. When all participants had received the three treatments, Traditional, MMV-Book, and MMV-Objects, the data were analyzed according to procedures described below.

The first analyses were to determine if the research had been influenced by either of two uncontrolled variables: (1) presentation order or (2) variation among the three observers. Those were calculated using WINKS 4.6 software for the one-way repeated measures analysis of variance (ANOVA) and Scheffé multiple comparisons test.

Test for Effect of Presentation Order

Although one would not expect patients with stage two Alzheimer's disease to be influenced by a psycho-religious exercise—the treatment—that occurred a week earlier, the presentation order was rotated equally among three possible sequences in a Latin Square design so that any influence of presentation order was identifiable, if extant. Descriptive data on presentation order were shown as table 6 above. The one-way repeated measures ANOVA and Scheffé multiple comparisons tests were used, and showed that at the 0.05 significance level the means of any two of the three groups were not significantly different. Data of these calculations are shown in table 8. It is therefore assumed that the findings of the study were not influenced by the order of presentation of the treatments. The printout from the Winks 4.6 calculations appears as appendix 9.

Table 8. The Scheffé Multiple Comparisons Test for Effect of Presentation Order

Comparison	Critical Difference	s	Critical s (.05)
Mean First – Mean Second	93.4167	1.743	2.53
Mean First – Mean Third	53.4167	(Do not test)	
Mean Third – Mean Second	40.0000	(Do not test)	

Test for Effect of Observers

Studies that gather data from multiple observers must show that the scores are not influenced by variations among the observers. The first steps toward validity of observer data are the careful selection of observers, followed by carefully training them in precise methods of gathering specifically identified quantifiable units of data. These procedures were followed and were described in chapter 3.

Subsequent to gathering data, the data were examined to determine if there was significant variation among the observers. Descriptive data were shown in table 7, above.

These data were analyzed using one-way repeated measures ANOVA and the Scheffé multiple comparisons test. To remove the influence of the treatment from the analysis of observer reliability, observers' scores were compared for each of the three treatment conditions. Data of these calculations, shown in table 9, indicated that at the 0.05 significance level the data gathered by the three observers were not significantly different. It was therefore assumed that the findings of the study were not influenced by the variations of perception within the observers, but were accounted for by other factors. The printout from the Winks 4.6 calculations appears as appendix 10.

Table 9. Scheffé Multiple-Comparisons Test for Effect of Observer

Comparison	Critical Difference	s	Critical s (.05)
Mean Observer KG – Mean Observer SH	145.O	1.676	2.627
Mean Observer KG – Mean Observer MK	145.0	(Do not test)	
Mean Observer MK – Mean Observer SH	0.0	(Do not test)	

Statistical Analysis

The hypotheses were tested by one-way repeated measures ANOVA followed by the Scheffé multiple comparisons test to identify the source of variance. Both tests were calculated using WINKS 4.6 software.

Hypotheses 1 tested for influence of the three treatments on the observable affective experience (pleasure) of women with mid-stage dementia. There was a significant difference between MMV-Book and TMV and between MMV-Objects and TMV. There was no significant difference between MMV-Book and MMV-Objects.

Hypotheses 2 tested for influence of the three treatments on the degree of alertness of women with mid-stage dementia. There was a significant difference between MMV-Book and TMV and MMV-Objects and TMV. There was no significant difference between MMV-Book and MMV-Objects (see tables 8, 9, 10, and 11).

Hypotheses Examining Observable Affective Experience

The WINKS 4.6 program for repeated measures ANOVA (TexaSoft 1999, 4.28) operated in two stages. It first provided an ANOVA test of the repeated factor (in this case, the three treatments: TMV, MMV-Book, and MMV-Object) to test if a statistically

significant difference lay anywhere within the data and calculated an approximate p value to indicate the statistical probability that the difference was due to chance. It then used the Scheffé multiple comparisons test as a further examination to identify more specifically the source of difference. For the latter, WINKS 4.6 offered only a test at the .05 level of significance.

The first hypothesis examined the influence of each of the treatments upon the observable affective experience of the participants. For this set, a difference was detected with an approximate p value <.001. The hypothesis was discussed below.

Null Hypothesis 1 (H_o1): There was no significant difference between the effects of Traditional Ministry Visitation (TMV), Multi-sensory Ministry Visitation-Book (MMV-Book), and Multi-sensory Ministry Visitation-Object (MMV-Objects) on the observable affective experience of women with mid-stage dementia as measured by the Observed Emotion Rating Scale (OERS).

An ANOVA was applied to determine if there was significant difference among the three treatments. The sum of the squares between was 1,307,733.00 with 23 degrees of freedom. The sum of the squares within was 1,766,116.00 with 48 degrees of freedom. The mean of the squares was 480,453.80 with 2 degrees of freedom. The f-value was 27.45 and the approximate p-value was <0.001. Since the p-value was less than 0.05 the hypothesis of no difference was rejected. There appeared to be a significant difference among the three ministry treatments in the observable affective experience of women with mid-stage dementia.

A Scheffe procedure was applied to locate the difference among the three ministry treatments. The critical difference between mean MMV-Book treatment and mean TMV

was 273.8334; the calculated s-value was 7.170 and the critical value was 2.53. Since the calculated value was larger than the critical value, there appeared to be a significant difference between MMV-Book and TMV. The critical difference between mean MMV-Objects and mean TMV was 198.7084; the calculated s value was 5.203, and the critical s value was 2.53. Since the calculated s value was larger than the critical value, there appeared to be a significant difference between MMV-Objects and TVM. The critical difference between mean MMV-Book and mean MMV-Objects was 75.1250; the calculated s value was 1.967, and the critical value was 2.53. Since the calculated s value was less than the critical value, there appeared to be no significant difference between MMV-Book and MMV-Objects treatments. The calculation of the ANOVA was in table 10 and the calculation of the Scheffe Multiple Comparison was in Table 11.

Table 10. Repeated Measures ANOVA on Observable Affective Experience

Source	S.S.	DF	MS	F	Appx p
Between Participants	1307733.00	23			
Within Participants	1766116.00	48			
Rep. Factor	960907.70	2	480453.80	27.45	<.001
Error	805208.20	46	17504.53		
Total	3070292.00	71			

Table 11. Scheffé Multiple Comparisons Test for Hypotheses 1-3, Effect of Treatment on Observable Affective Experience (Pleasure)

Comparison	Critical Difference	s	Critical s (.05)

Hypothesis 1: Mean MMV-Book – Mean TMV =	273.8334	7.170	2.53
Hypothesis 2: Mean MMV-Objects – Mean TMV =	198.7084	5.203	2.53
Hypothesis 3: Mean MMV-Book – Mean MMV-Objects =	75.1250	1.967	2.53

Hypotheses Examining Alertness

Null Hypothesis 2 (H_o2): There was no significant difference between the effects of TMV, MMV-Book, and MMV-Objects on the alertness of women with dementia.

An ANOVA was applied to determine if there was a significant difference in alertness in the three different treatments. The sum of the squares between was 506350.00 with 23 degrees of freedom. The sum of the squares within was 691,200.00 with 48 degrees of freedom. Mean squares was 102,200.00; the f value was 9.66; and the p-value was <0.001. Since the p value was less than 0.05, there appeared to be significant differences in alertness among the three treatments.

A Scheffe Multiple Comparison was applied to locate the difference. The critical difference between MMV-Book and TMV was 125.00; the calculated s value was 4.209; and the critical s was 2.53. Since the calculated s value was larger than the critical s value, there appeared to be significant difference between MMV-Book and TMV treatments. The critical difference between MMV-Objects and TMV was 95.00; the calculated s value was 3.199; and the critical s value was 2.53. Since the calculated s value was larger than the critical value, there appeared to be a significant difference

between MMV-Objects and TMV treatments. The critical difference between MMV-Book and MMV-Objects was 30.000; the calculated s value was 1.010; and the critical s value was 2.53. Since the calculated s value was less than the critical s value, there appeared to be no significant difference between MMV-Book and MMV-Objects treatments. The ANOVA calculation was reported in table 12 and the Scheffe Multiple Comparison calculation was reported in table 13.

Table 12. Repeated Measures ANOVA on Degree of Alertness

Source	S.S.	DF	MS	F	Appx p
Between Participants	506350.00	23			
Within Participants	691200.00	48			
Rep. Factor	204400.00	2	102200.00	9.66	<.001
Error	486800.00	46	10582.61		
Total	1197550.00	71			

Table 13. Scheffé Multiple Comparisons Test for Hypotheses 4-6, Effect of Treatment on Degree of Alertness

Comparison	Critical Difference	s	Critical s (.05)
Hypothesis 1: Mean MMV-Book – Mean TMV =	125.0000	4.209	2.53
Hypothesis 2: Mean MMV-Objects – Mean TMV =	95.0000	3.199	2.53
Hypothesis 3: Mean MMV-Book – Mean MMV-Objects =	30.0000	1.010	2.53

Data from Informal Observation and Participant's Comments

On two occasions, the participants attempted to include the observer in the interactions. The observer appeared friendly, but spoke minimally and the participant soon lost interest in the observer.

On many occasions the participants displayed a pleasant demeanor during the entire treatment time, however, this was not counted as pleasure as it was unknown whether the individual always appeared pleasant or if it was the result of the treatment. Only smiles and laughter were counted as pleasure. One participant appeared to have trouble smiling, and only brief smiles appeared during any of the treatments, yet she was alert the entire time and she responded verbally.

In the beginning, most individuals had to be encouraged to touch the pages of the book or to hold the objects in the basket. A social worker at one of the facilities stated that some of the residents had a problem with depth perception and might not realize that there were objects to touch. Another social worker suggested that learned docility might be a factor—in a nursing home setting residents often became accustomed to being told when to eat, to take medicine, bathe, and other things. Another possibility was that older people might not consider it polite to touch or take something unless invited to do so. Most individuals did not want to touch the wheat. Perhaps it appeared to be prickly.

Three individuals asked where they could buy one of the books; many commented that they liked the book. All of the participants were attracted to the sheep in the basket, most at least smiled at it, some laughed aloud when they saw it, but no one attempted to keep it when it was time for the presenter to leave.

The sense of smell often diminishes with age. Many of the residents could not smell the cedar or the perfume. There was usually a response if the participant was able to smell the odors.

Participants SS and CM cried at the end of the book. The participants did not appear to be in distress, but merely touched by the content of the visit or perhaps by recollections triggered by the experience. The tearfulness seemed associated with positive attitudes about their religious faith. This reaction did not occur with the basket visitation or during the Traditional Ministry Visitation.

The husband of one resident stated that the presenter would "not get anything out of BB." BB appeared to be completely non-verbal in his presence. After the husband left the room, BB was attentive to the lesson, laughed, murmured words that were indistinguishable, and even winked at one point. The book brought more responses from BB than the other treatments, although she responded to all three treatments.

As NG began to look at the book, she commented that she didn't remember much about Jesus. As the book was read to her, however, she went from repeating things that the presenter was reading to saying things about Jesus that had not been said. It appeared that some spiritual memory had been awakened. When the presenter talked about the love and care Jesus gave, NG visibly brightened and appeared to internalize the message. This was not something that could be measured, but there was a difference in her demeanor at that point. Both the presenter and the observer noticed when this happened. At other times during the research, two other residents appeared to have a moment when their spiritual memory was tapped and a visible change lit their faces.

One of those instances occurred when EW was reading the sensory book aloud. When she came to the line "Jesus is with you when you are afraid," she paused and looked at the sentence again, and murmured "hmm" and smiled. It was revealed by the social worker, that EW is often frightened and that she did not respond to many activities.

EM smiled and appeared to light up in response to the words "He is always with us" during the basket visitation. The observer commented that her spirituality appeared to be touched at that particular moment.

OP was focused on her pain as the session with the basket began. During the first few minutes, she mentioned three times that she hurt. As the presenter began to take objects out of the basket, however, and OP began touching and holding the objects and sniffing the perfume and trying to decide what kind of odor it was, she no longer talked about her discomfort. She did not mention pain during the remainder of the visit.

The picture of Jesus brought a smile to the face of most of the participants and several made comments such as "I've seen this before" and "He was beautiful." Almost all participants recited the Lord's Prayer in unison with the presenter, and several individuals could recite other Bible verses as well. One participant commented that "the basket of things made me think."

CHAPTER 5

RESEARCH INTERPRETATION

This research examined and compared three forms of ministry visitation on the affective experience of individuals with mid-stage dementia. The methods of data collection and data analyses were discussed in chapter 4, and explanations, conclusions, and implications are addressed in chapter 5.

Summary

Individuals with a history of religious faith and practice continued to have a need for spiritual connectedness even in the throes of dementia. A number of researchers and other professionals, who worked with individuals with dementia, believed that cognitive approaches of ministry to this population did not help dementia victims access their religious roots. However, for the most part, both group worship and one-on-one ministry to residents of congregate living facilities had been done via the traditional, cognitively-based style of worship. It was important for ministry teams to help people with Alzheimer's disease and other dementias make the spiritual connection.

Alternative forms of ministry to people with dementia had seldom been researched. The effect of music was an exception. Anecdotal reports of non-cognitive methods of ministry were documented, but virtually no empirical research had been available in the literature.

Using Montessori-style, multi-sensory methods, this research sought to determine whether there was a statistically significant difference in the affect of women with mid-stage dementia when Traditional Ministry Visitation was employed as compared with two forms of Multi-sensory Ministry Visitation. A presenter conducted ten-minute ministry sessions, while a trained observer documented pleasure, in the form of smiles or laughter, and alertness, described as the amount of eye contact made with the presenter or the objects. The Observed Emotion Rating Scale (OERS) was used to record the amount of time a participant displayed pleasure and alertness.

The mean scores for both the pleasure and the alertness measures were lowest for the Traditional Ministry Visit (TMV) and highest for the Multi-sensory Ministry Visit-Book (MMV-Book). For TMV, MMV-Objects, and MMV-Book, the means for pleasure were 63.08, 263.12, and 325.08 seconds respectively, and for alertness the means were 462.50, 557.50, and 587.50 seconds respectively. The women in this study displayed four times as many seconds of pleasure when shown the multi-sensory objects and five times more seconds of pleasure when the multi-sensory book was used than they showed during a Traditional Ministry Visitation.

Two research hypotheses were tested. Research hypothesis 1 predicted a significant difference between the effects of Traditional Ministry Visitation (TMV), Multi-sensory Ministry Visitation-Book (MMV-Book), and Multi-sensory Ministry Visitation-Objects (MMV-Objects) on the affective experience of women with mid-stage dementia. There appeared to be a significant difference between TMV and MMV-Book at the .05 confidence level. There appeared to be a significant difference between TMV

and MMV-Objects at the .05 confidence level. There did not appear to be a significant difference between MMV-Book and MMV-Objects at the .05 confidence level.

Research hypothesis 2 predicted a significant difference between the effects of TMV, MMV-Book, and MMV-Objects on the degree of alertness observed in women with mid-stage dementia. There appeared to be a significant difference between TMV and MMV-Book at the .05 confidence level. There appeared to be a significant difference between TMV and MMV-Object at the .05 confidence level. There did not appear to be a significant difference between MMV-Book and MMV-Objects at the .05 confidence level.

Conclusions

Research hypotheses 1 and 2 were supported in this research. There was a significant difference between the effects of Traditional Ministry Visitation and both the MMV-Book and the MMV-Objects on the observable measure of pleasure and alertness of women with mid-stage dementia.

However, there was no significant difference between the two multi-sensory ministry techniques, MMV-Book and MMV-Objects, in the measurements of pleasure or alertness in the twenty-four women with mid-stage dementia.

As hypothesized, women with mid-stage dementia responded much more positively to ministry that utilized Montessori-style, multi-sensory techniques. The specific type of multi-sensory technique that was employed appeared not to be relevant, but in the current study women with dementia showed significantly longer periods of alertness and increased pleasure in response to multi-sensory ministry than to the more traditional cognitive, didactic approach.

Implications

As the literature suggested, people with dementia could, and often did, express their spiritual nature when given the opportunity to do so. When diagnosed with dementia, many individuals expressed concern that they would be unable to access their spiritual beliefs as the disease progressed. Unless a consistent effort is made to remind dementia sufferers of their spirituality, those fears could be realized.

As noted earlier, individuals with dementia are underserved by the ministry. If pastors and church visitors were better able to help the confused elderly access their spirituality by means of multi-sensory tools, it would be possible for this population to enjoy a better quality of life. More and more churches will be forced to address the concerns of all older adults, including those with dementia, as the general population ages.

Those who worked with dementia patients asserted that additional training was necessary for the pastorate to meet the ever-growing need to respond and to minister to people with Alzheimer's disease. Tools, such as the multi-sensory books or ministry baskets used in this study, along with instructions for working with the demented, could be an important aid to church members who felt called to ministry with the aged population.

As mentioned in the text, Montessori utilized multi-sensory means to train children. Both the multi-sensory book and the basket of objects that were developed by the researcher could be used by churches for children's ministries and with adults with developmental disabilities as well as by people with AD. Older adults who do not have dementia, but who have visual deficits may also be attracted to these ministry aids.

Future Research

There were a number of related paths that could be pursued in future research. For example, this same research might be done with those who are in the latter stage of dementia. This research could also change its focus to faiths other than the Christian tradition. Future research might look at male's responses as well.

Follow-up to this study could include education with church members on the general subject of dementia and the use of multi-sensory ministry tools like those presented in this research to aid ministry to confused elderly. A questionnaire could be developed to gauge church visitors' perception of effectiveness when a multi-sensory tool is utilized.

Anyone researching individuals in assisted living and nursing home facilities should be apprised of the complexity of arrangements. Seven facilities were approached for permission to do the present study. One refused to participate due to confidentiality issues. Two other facilities agreed to assist, but one of those received no consent forms back from families. The other one received two consent forms, but one of the residents died, and the family of the other withdrew consent before the study began. At three out of the four facilities that allowed the research to take place, the researcher had personal contacts. The fourth facility was a Christian-based assisted living.

Another complexity revolved around the scheduling of sessions. Since people with dementia often become agitated in the late afternoon and evening, mornings or early afternoons are the best times to conduct research. Mornings, however, were busy times in the facilities, and the researcher often arrived to find the subject engaged in an activity,

being bathed, eating a meal, or taking a nap. The researcher often waited for half an hour or longer for the subject to be available.

Distractions were another problem, especially in the nursing homes. It was sometimes difficult to find a private corner where there were few distractions to conduct the lessons. The intercom made announcements regularly, there were cries and moans, nurses and assistants bustled about, and medicine was administered. Most residents shared a room and sometimes the roommate was asleep, at other times she was entertaining company, and at times the roommate attempted to converse with the presenter or observer during the sessions, making it difficult to complete a session.

Even with the difficulties, ministering to people with dementia could be rewarding to both the recipient and the pastoral worker. Quality of life for all people, including those with cognitive disorders, encompasses activities in four life domains: work, leisure, self-care, and spiritual. As related research suggested, the spirituality of people with dementia was a subject that needed to be explored further if quality of life was to be enhanced. Stuckey 2002, Katsuno 2003, Snyder 2003, and others agreed that the time had come to address the need.

APPENDIX 1

SURVEY OF MINISTRY WITH DEMENTIA PATIENTS BY CHURCHES IN THE DAYTON-CHATTANOOGA AREA

INFORMAL SURVEY OF MINISTRY WITH DEMENTIA PATIENTS BY CHURCHES IN THE CHATTANOOGA AREA

- Bethel Temple Assembly of God reported that they were not doing nursing home ministry at the present time, nor did they currently have any members with AD.

- Brainerd Baptist held nursing home services on Tuesdays, Wednesdays, and Thursdays. All residents were included in the service with no special provisions for people with dementia.

- Calvary Baptist had a nursing home service once a month. They sang, talked to residents, and brought a short message. The pastor reported that they were not doing anything special for people with AD. A member of the congregation who had Alzheimer's disease came to a recent service, and the pastor recognized that the individual did not follow the service.

- Central Baptist, Hixson had a homebound ministry on a monthly basis that included people in care facilities. They tried to encourage them. Most of the volunteers were older and had at least some experience with Alzheimer's victims and knew what to expect. The volunteers were informed of some aspects of the population before visiting people with AD.

- First Baptist, Dayton held a Sunday School class 10:00-10:30 A.M. led by a Deacon on Sundays. The Deacon also visited with the folks individually. He admitted that he did not know how to deal with some of the people with AD and just did the best he could.

- Daisy Church of God held a church service in a nursing home, then a trio went to the rooms to sing, talk, and pray with people.

- First Baptist, Soddy-Daisy did not have a ministry to nursing homes and only occasionally visited members in nursing homes.

- Sequoyah Church of God held a worship service in a nursing home three times a month in which there was a short message and prayer.

- Soddy United Methodist Church's pastor, George Dunbar, visited a nursing home occasionally. He also held a service occasionally where he sang old hymns with the residents. Reverend Dunbar’s father was in the VA nursing home and had dementia.

Conclusion: This brief survey suggested that some pastors were uncertain about how to address the spiritual needs of people with dementia.

APPENDIX 2

SCRIPT FOR TRADITIONAL MINISTRY VISITATION

SCRIPT FOR TRADITIONAL MINISTRY VISIT

This is the script which was used with each of the twenty-four participants as a sample of a traditional ministry visit. The content is as much like the MMV-Book and MMV-Objects treatment as was possible without using objects. The readings are from the King James Version of the Bible.

"I am going to talk about the life of Jesus. You have probably heard this story before. There were shepherds watching their sheep in the field when an angel came to them and announced the birth of Jesus. In Luke 2:10, 11, and 14 we are told what the angel said." At this point the presenter opened the Bible and read these familiar passages "Fear not; for, behold, I bring you good tidings of great joy. For unto you is born this day in the city of David a Savior, which is Christ the Lord. Glory to God in the highest, and on earth peace, good will toward men.

"Jesus was born in a manger in Bethlehem. The shepherds went right away to worship Jesus. Jesus had come to teach that God loves us. Three wealthy kings also came from far away to honor Jesus. They bowed down to him and gave him gold, frankincense, and myrrh—those are expensive perfumes. The kings knew that Jesus was the son of God and that he loves us.

"Jesus grew up around his father's carpenter shop and probably helped Joseph make things out of cedar. Jesus grew strong in spirit and he was filled with wisdom. When Jesus was 12 years old, he went with his parents to the Temple in Jerusalem. He

listened to the teachers and asked them questions and in Luke 2:41-52 it says…" Luke 2:41-52 was read, ending with "He grew in wisdom and stature and in favor with God and men."

"As an adult, Jesus taught about God's love and about how to live. He often taught out in the fields. He told stories to help people understand what he was teaching. Jesus taught that the most important commandment is (Mark 12:30 was read) 'thou shalt love the Lord thy God with all thy heart, and with all thy soul, and with all thy mind, and with all thy strength.'

"Jesus told about a man who sold everything he had to buy a beautiful pearl. But we know that heaven is worth more that the most precious pearl. And heaven is more beautiful than any pearl.

"Jesus loves you and helps you and protects you. Jesus taught that as a shepherd loves and cares for his sheep, God loves and cares for his children. Jesus is like a good shepherd who will risk his own life to rescue a lost sheep. Jesus loves you even more than the sheep in the field. His love is complete and perfect. In John 15:9 we read what Jesus said 'as the father has loved me, so have I loved you.'

"Jesus walked with his friends and taught them. Jesus is with you too. He is with you when your life is rough, when you are sad, lonely or afraid. Jesus said 'I will be with you always to the very end of the age.'

"Jesus hears, our every prayer. We can talk to him at any time. Jesus wants each person to know him. In Revelations 3:20 Jesus says, 'Behold I stand at the door and knock: if any man hears my voice and opens the door, I will come in.' The perfect love of Jesus casts out fear.

"Jesus taught us to pray." The Bible was opened to Matt: 6:9-13. "I'd like to close with the Lord's Prayer, and you can say it with me if you'd like." After the Lord's Prayer, a personal prayer for the individual was said.

APPENDIX 3

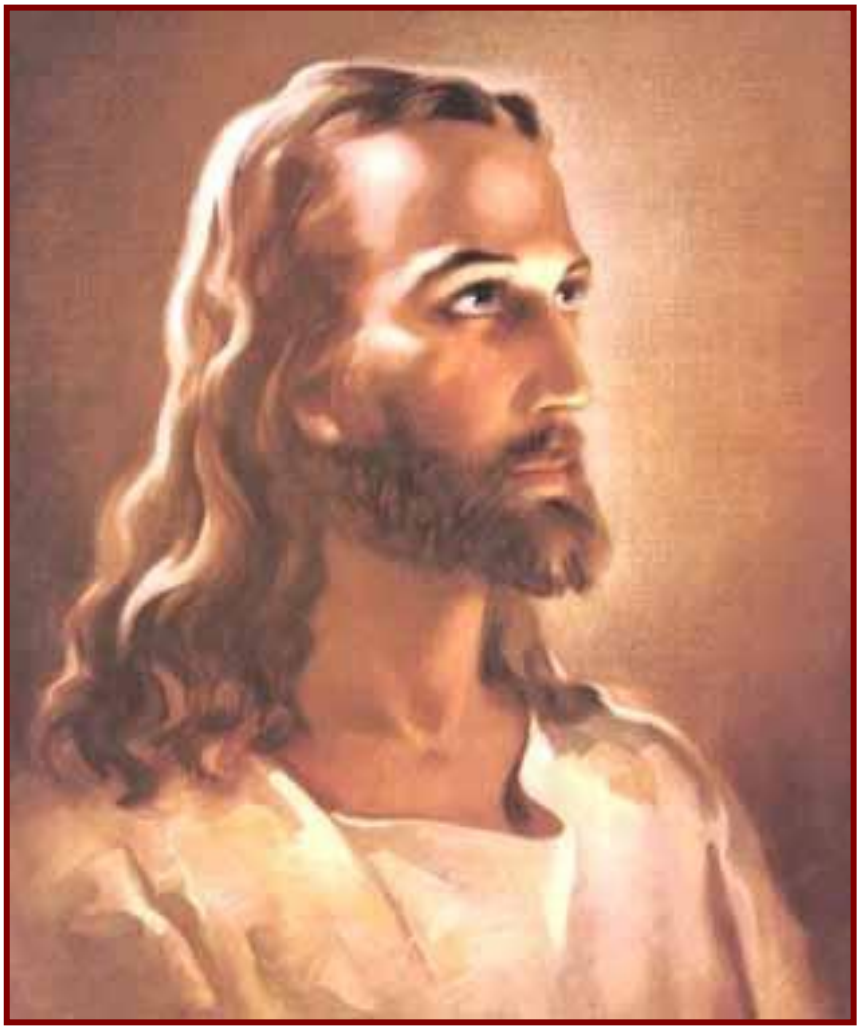
MULTI-SENSORY MINISTRY VISIT-BOOK

MULTI-SENSORY MINISTRY VISIT-BOOK

The book used in treatment MMV-Book is represented on the following twenty-nine pages. The book was designed to accommodate needs typically found among persons in stage two dementia: (1) large, sans-serif type, (2) realistic artwork, (3) bright colors, (4) plain, direct syntax using basic vocabulary. To the extent possible, the pictures chosen had received wide circulation to the generational cohort.

All of the pictures in the actual book were printed in bright colors. In addition, some of the images or text in the representation were altered in size or proportion to fit the margin requirements of the dissertation. Many pages were taken directly from the electronic master copy, but those with multi-sensory appliqués were scanned.

In the book, text was on the left and the pictures are on the right. The book was much more three-dimensional than it appeared in this representation, and included two pages with stimulating aroma—cedar wood, and frankincense perfume.



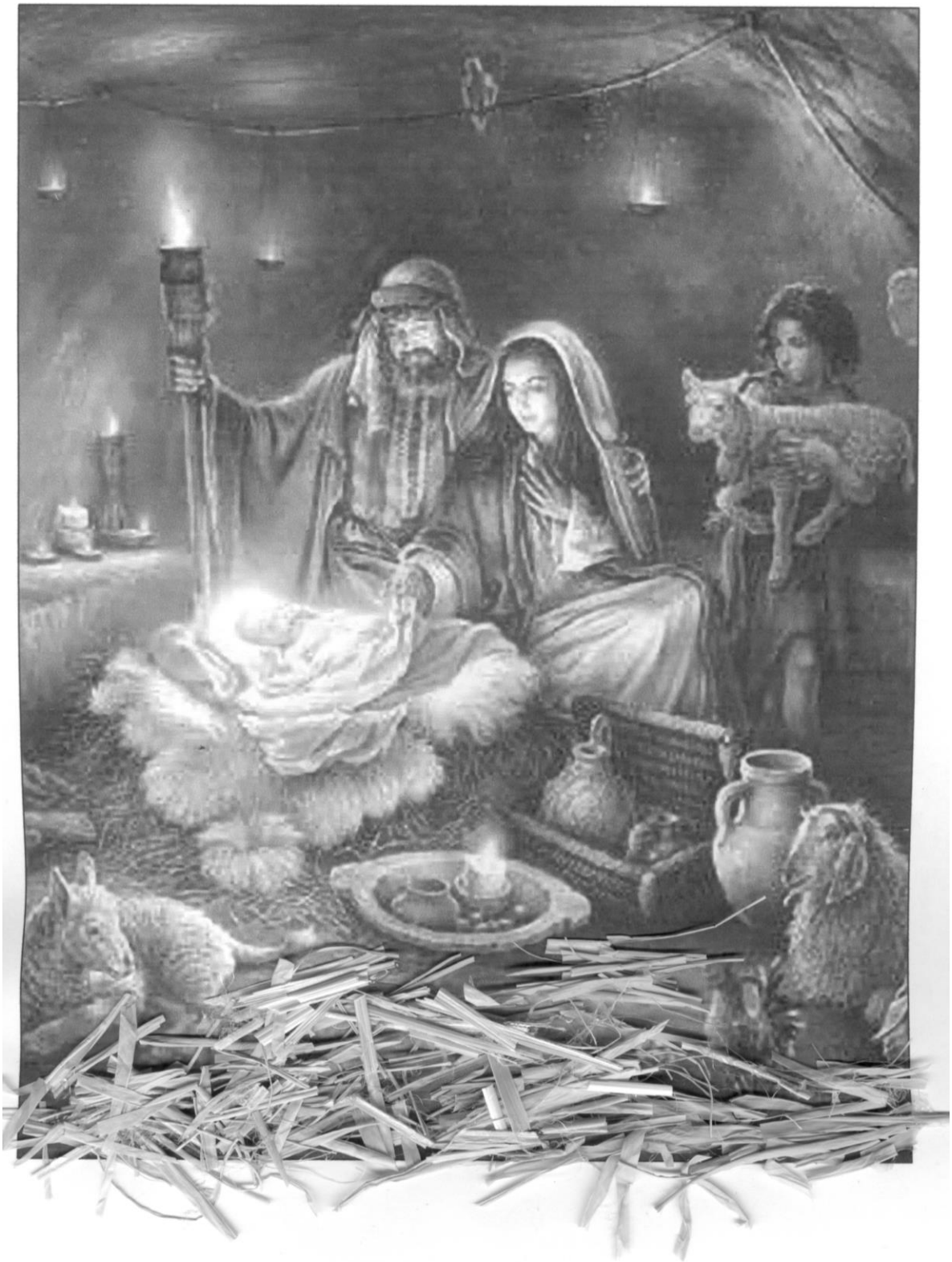
REMEMBERING THE LIFE OF JESUS

Shepherds heard an angel announce the birth of Jesus, “I bring you good tidings of great joy. Glory to God in the highest, and on earth peace, good will to men.”

Luke 2:10, 14

Jesus was born in a manger. The shepherds went there right away to worship him. They knew that Jesus had come to teach that God loves us all.

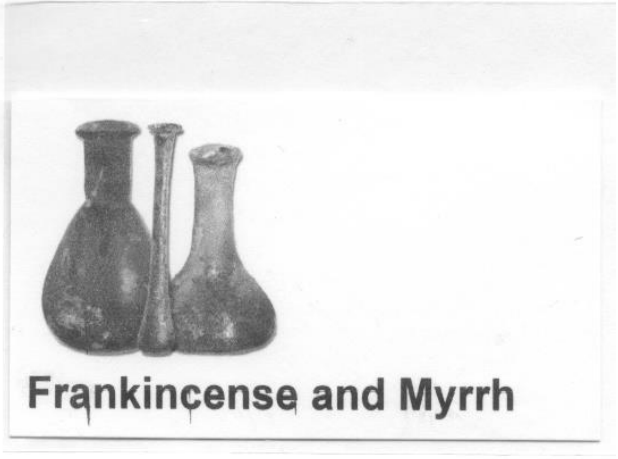
Luke 2:16-20



Later, three kings came from far away. They bowed down to honor Jesus, and gave him gold, frankincense, and myrrh. The kings knew that Jesus was God's son and that he loves us.

Matthew 2:1-12


ΑΥΑΘ ΘΟ ΒΕΡΣΙΘ ΘΗΙΝΑ
ΑΥΑΘ ΘΟ ΒΕΡΣΙΘ


Frankincense and Myrrh

When Jesus was a boy he was often in the carpenter shop with his father. He probably helped make things out of cedar.

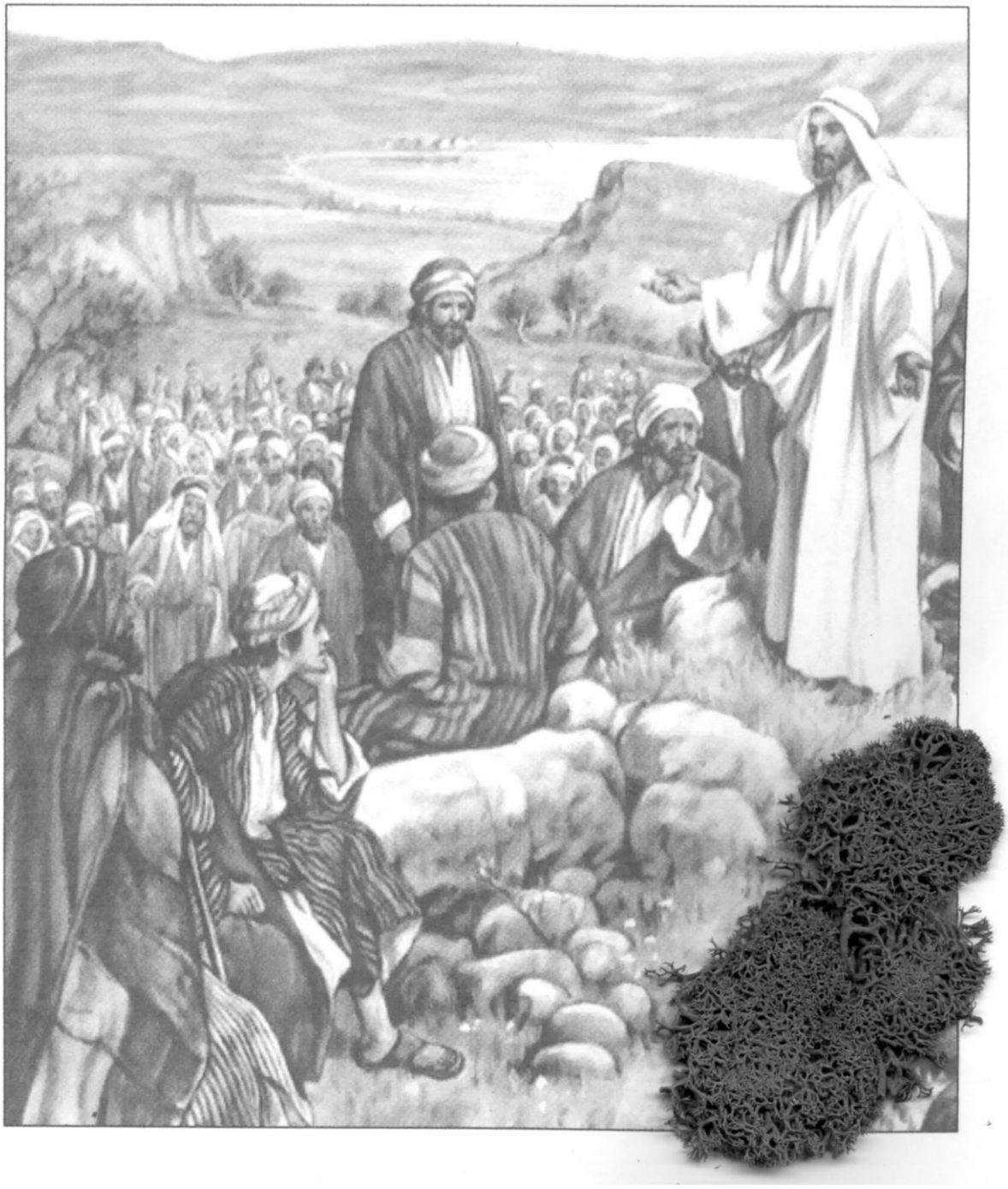
Mark 6:3

When Jesus was twelve he went with his parents to the Temple in Jerusalem. He listened to the teachers there and asked questions. Jesus “grew in wisdom and stature, and in favor with God and men.”

Luke 2:41-52

As an adult, Jesus taught about God's love and about how to live. Usually he taught outdoors. Jesus often told stories to help people understand what he was teaching.

Matthew 13.34-35

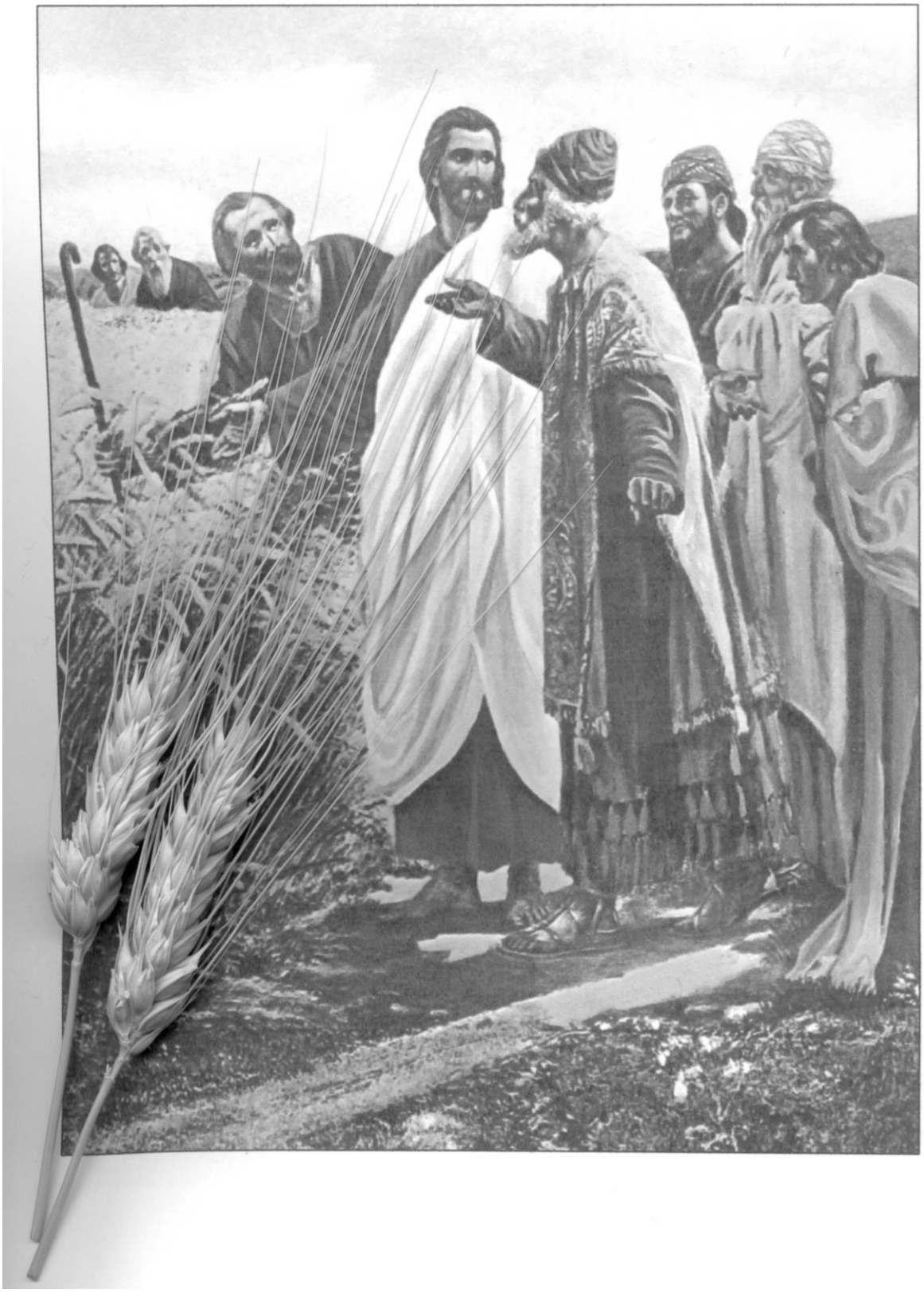


Jesus told about a man who sold everything he had to buy a beautiful pearl. Heaven is worth more than an expensive pearl. Heaven is more beautiful than any pearl.

Matthew 13:45-46; Revelation 21:15-27

Everywhere Jesus went he taught about God's love. He even taught when he was in the fields. Jesus said the most important commandment is to "Love the Lord God with all your heart, soul, and mind."

Matthew 12:1-8, Mark 12:28

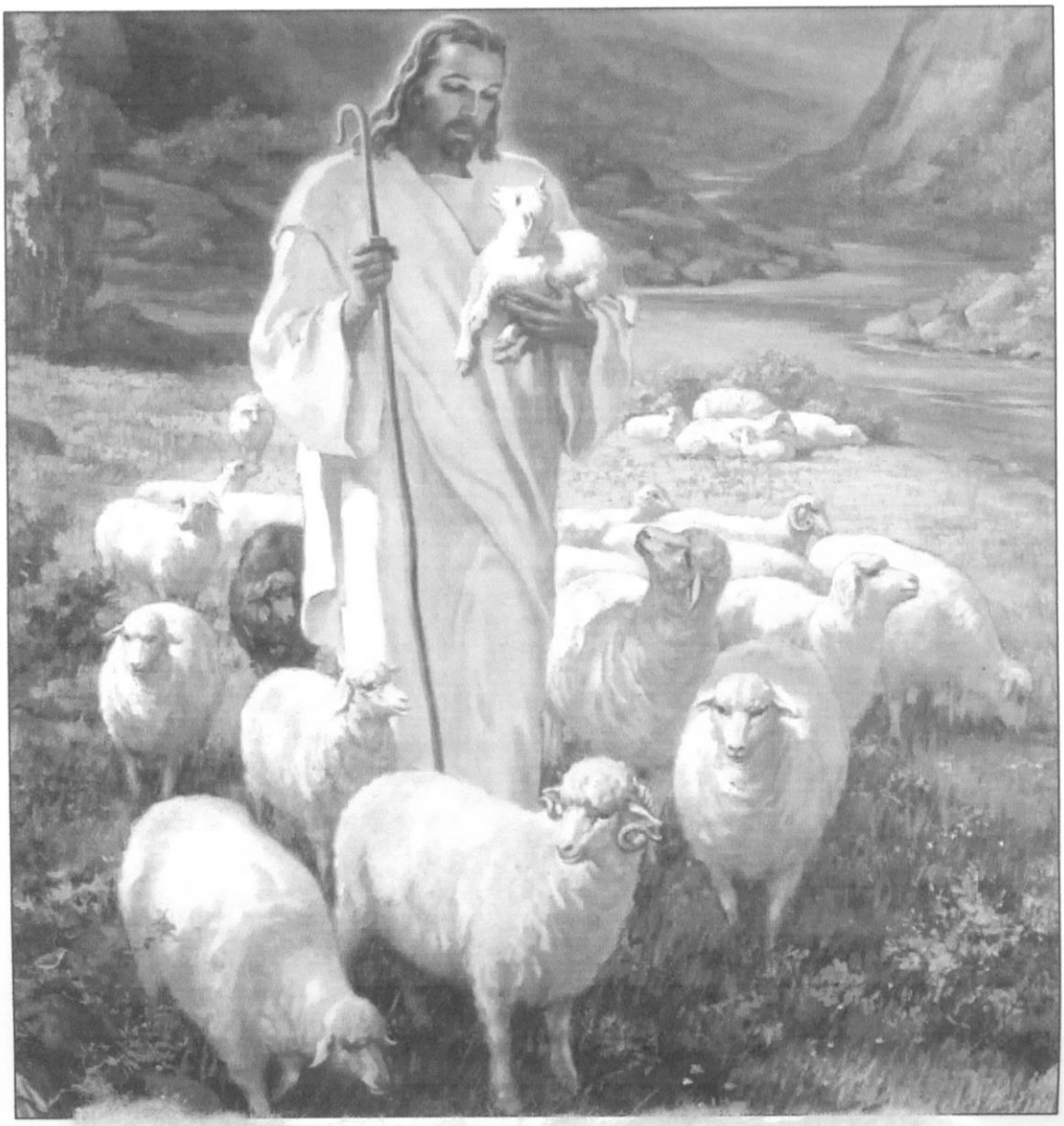


Jesus is like a good shepherd who will risk his own life to rescue a lost sheep. Jesus will help you and protect you. Jesus loves you.

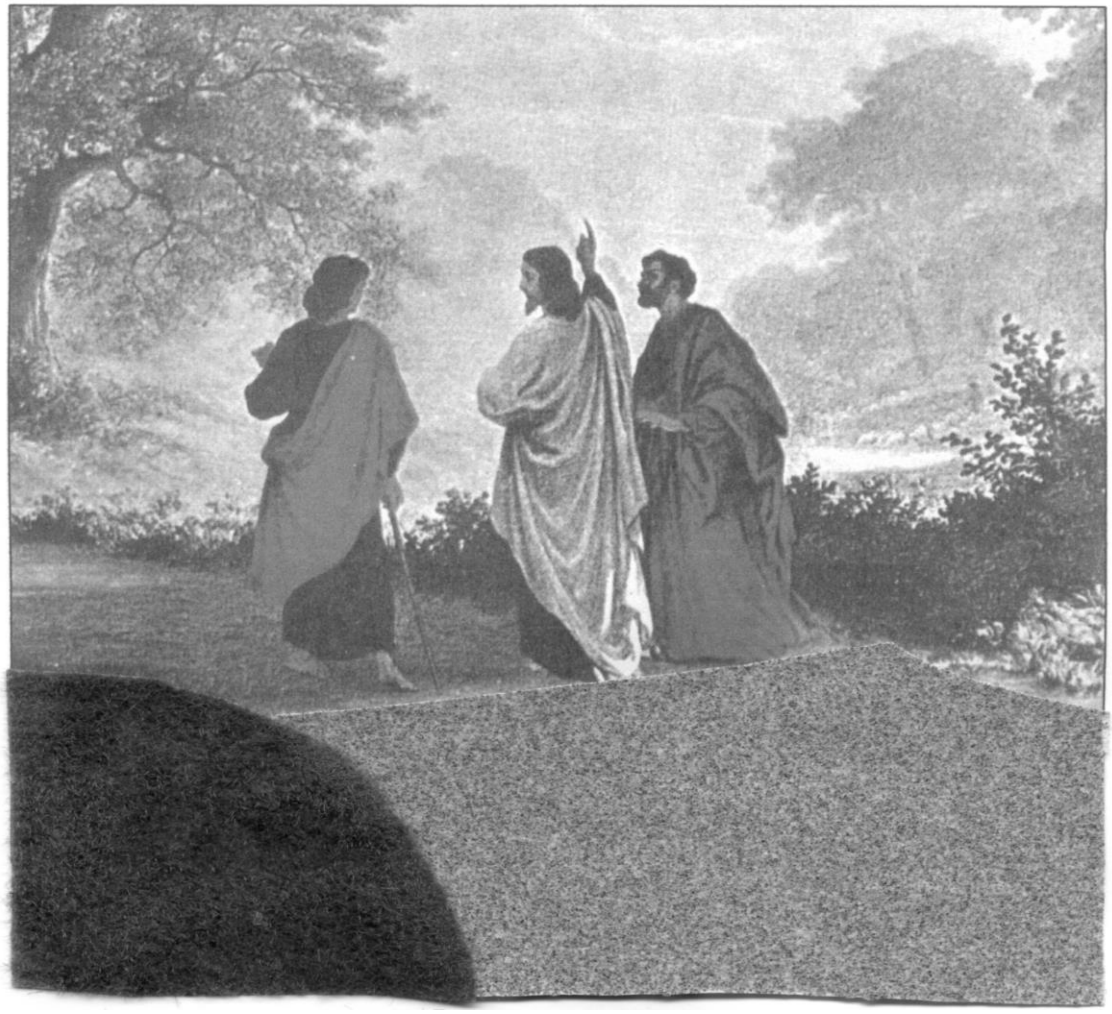
John 10:14-18

Jesus loves you even more than he loves the sheep in the field.
Jesus said, “As the Father has loved me, so have I loved you.” That is complete and perfect love.

John 13:1; 15:9; Romans 8:34-39; John 15:9



Jesus walked with his friends and taught them. Jesus is also with **you**. When your life is rough, Jesus will be with you. He is with you when you are sad. Jesus is with you when you are afraid.



Jesus said, “I will be with you always, to the very end of the age.”

John 15:15; Matthew 28:20

Jesus said, “Behold, I stand at the door and knock. If any one hears my voice and opens the door, I will come in.” Jesus is always there for you. Jesus is a perfect friend and his perfect love casts out fear.

Revelation 3:20

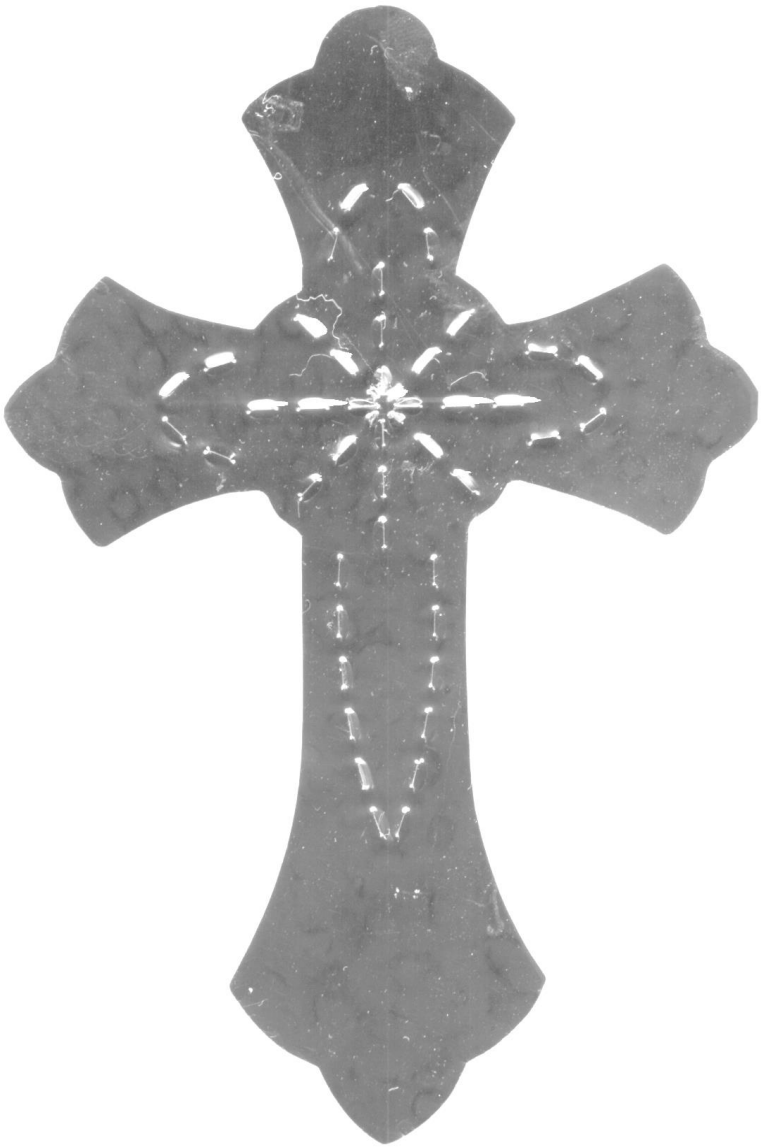
We can talk with Jesus.
Jesus hears us pray.

This is the prayer that Jesus taught:

“Our Father which art in heaven, hallowed be thy name. Thy kingdom come, thy will be done in earth, as it is in heaven. Give us this day our daily bread.

And forgive us our debts, as we forgive our debtors. And lead us not into temptation, but deliver us from evil: for thine is the kingdom, and the power, and the glory, forever." Amen.

Matthew 6:9-13



APPENDIX 4

MULTI-SENSORY MINISTRY VISITATION-OBJECTS

LESSON WITH MULTI-SENSORY MINISTRY VISITATION-OBJECTS

The ministry basket contained objects that were used in the lesson (see figures 1 and 2). The basket contained the following: A familiar 8x10 laminated picture of Jesus, a plush lamb, an eight-inch wooden cross, a bottle of frankincense and myrrh, a box of gold coins, a bouquet of wheat, a piece of richly scented cedar, a large imitation pearl, a piece of sandpaper, and a slightly larger scrap of red satin (see figures 1 and 2).

The content of the lesson as described below was similar to the lesson given in the TMV and MMV-Book treatments. Following introductions, reiteration of the purpose for the visit, and a moment of small talk to put the participant at ease, the lesson commenced.

"You have probably heard this story before." The participant was shown the picture of Jesus "I'm going to talk a little about the life of Jesus. You may have seen this picture in the past." They were given time to look at the picture and respond in any way they might.

"An angel told some shepherds in the field about Jesus being born. The angel said 'I bring you good tidings of great joy. Glory to God in the highest, and on earth peace, good will toward men.' Jesus was born in a manger in Bethlehem, and the shepherds went there right away to worship him.

"Wealthy kings came from far away, too. They bowed down to worship Baby Jesus. The kings brought Jesus gold, frankincense, and myrrh—that's perfume." Objects were withdrawn from the basket one at a time, and the participants were given a moment

to respond—to handle the coins, the bottle of perfume, and sniff the perfume as they desired.

"When Jesus was a boy, he was often in the carpenter shop with his father. He probably helped Joseph make things out of cedar." The individual was handed the piece of cedar and invited to sniff it.

"When Jesus was twelve he went with his parents to the Temple in Jerusalem. He listened to the teachers and asked questions. He 'grew in wisdom and stature and in favor with God and men.'

"When he was a man, Jesus taught about God's love and about how to live. He often told stories to help people understand what he was teaching. Jesus taught everywhere, even in the wheat fields." The wheat stalks were brought out and handled by the participant if desired. "Jesus taught that the most important commandment is to 'Love the Lord God with all your heart, soul, and mind and strength.'

"Jesus told about a man who sold everything he owned to buy a big beautiful pearl. But we know that heaven is worth more than any pearl and is more beautiful than the biggest, most expensive pearl." The pearl was brought out at this point.

"Jesus taught that as a shepherd loves and cares for his sheep, God loves and cares for his children." The lamb was shown and the participant was invited to hold it. "Jesus is like the good shepherd who will risk his life to save a sheep. Jesus will help and protect you in the same way. His love is complete and perfect. Jesus said 'As the Father has loved me, so have I loved you.'"

The participant was invited to touch the sandpaper. "Sometimes the road of life is rough like this sandpaper. Is your life ever rough like this? But Jesus walks along the

road of life with us and is a perfect friend every day. Jesus is with us when we're happy and when we're sad, and when we are afraid. When things are difficult, Jesus helps smooth out the rough places—like this." The presenter covered the sandpaper with the red satin.

"Jesus wants everyone to know him. He said 'Behold I stand at the door and knock. If anyone hears my voice and opens the door, I will come in.' We can talk with Jesus and he knows our troubles and Jesus hears all our prayers."

The cross was brought out. "This cross is a symbol of Jesus' love. Jesus taught us to pray. You may know the Lord's Prayer. If you do, we can say it together." The Lord's Prayer was recited, often in unison with the participant.

The picture of Jesus was picked up again and shown to the participant. "Jesus loves you. And the Bible tells us that he will be with all of us forever to the end of the world."

Figure 1. Materials Used in Treatment MMV-Objects

From left: wheat, lamb, cross, strip of cedar, frankincense in bottle that is a replica of an ancient perfume bottle, pearl in round box, picture of Jesus, replica ancient Roman coins in antique box, piece of satin, piece of sandpaper.

Figure 2. Materials Used in Treatment MMV-Objects

Clockwise, beginning at left: cross, picture of Jesus, lamb, box of coins, frankincense (barely visible), strip of wood, wheat, piece of satin with piece of sandpaper on top.

APPENDIX 5

INSTRUCTIONS FOR MINISTRY VISITORS

INSTRUCTIONS FOR MINISTRY TO PEOPLE WITH DEMENTIA

Introduce yourself even if you have seen the individual before. Call the person by name. Sit or stand at the participant's level. Gauge their ability to see and hear as both eyesight and hearing can diminish with age. You may have to talk loudly into the individual's ear or guide their hands to the objects.

Do not ask if they remember you as they may become worried or upset when they do not remember who you are. Comment positively on their clothes, hair, eyes, or something else. Explain that you are a visitor from the church and you've come to share a Bible lesson with them if that is all right. They may become concerned that you will ask something of them that they cannot do, so reassure them that you will read the lesson and all they have to do is listen. Tell them you will talk about the life of Jesus and that you have things to show them as you talk. Say something like "you've probably heard about Jesus your whole life."

As you show the picture, say "This is a picture of Jesus. You may have seen this picture before." Invite them to turn the page. If they do not want to, you can do it for them. Wait a moment to see if they will begin to read or if they touch the page or react in some other way before reading it to them. If they do not voluntarily touch the objects on the pages, invite them to do so by touching the objects yourself first.

When you come to the Lord's Prayer, tell them this is a prayer they may have heard before. Invite them to say it with you if they would like. Thank them for allowing

you to come and share with them. Keep the personal prayer at the end brief and positive. A phrase or a feeling you leave with them may remain with them for hours after the visit has concluded and it may even affect their disposition long after you have left.

APPENDIX 6

LETTERS TO REQUEST PERMISSION

LETTER TO REQUEST PERMISSION FROM FACILITY ADMINISTRATOR

Diana Walters
160 Barton Rd.
Dayton, TN 37321
Phone: 870-3864

January 25, 2004

Dear Facility Director (insert name),

As you can see from the enclosed letter to the family, I believe that my research will be beneficial to the person with dementia as well as to church members who minister to those with cognitive impairments.

During my research, the resident will receive special one-on-one activity sessions. My multi-sensory, Christian-based material will be presented only to those who are life-long professed Christians.

I believe that most families will appreciate the opportunity for their loved one to access their faith and to participate in research that may help other people with dementia get in touch with theirs. Most people have a need to do something useful with their life. This need does not necessarily end with a diagnosis of dementia.

Dr. John Stuckey of Messiah College has endorsed this research. He is an important researcher in the field of spirituality and dementia. He believes that my completed research will be an important addition to the current literature on dementia care.

I will contact you in about a week concerning my study. I hope you will consider allowing me to do this research at your facility after receiving authorization from the family or conservator. In my experience in assisted living facilities and nursing homes, I have found that families are delighted to have visitors give time and attention to their loved ones.

I am a regular nursing home visitor for First Baptist Church in Dayton. I am certain that Pastor Knox and other members of the congregation will attest to my good intentions.

I will contact you soon. Thank you for considering my request.

Sincerely,

Diana Walters

LETTER TO REQUEST PERMISSION FROM FAMILY MEMBER

Diana Walters
160 Barton Rd.
Dayton, TN 37321
Phone: 870-3864

April 18, 2004

Dear Family,

I am a doctoral student studying methods of helping people with dementia remember and experience their faith. I would like to include _____ in my study. I believe, and the research supports the belief, that people with dementia can continue to feel God's presence with proper cueing. And they should be provided every opportunity to continue their spiritual journey.

The problem is that many pastoral visitors don't know how to draw out spiritual memories in people with dementia. I believe my research will show pastors and church visitors a better way to reach people who suffer memory loss.

My research simply involves presenting women with dementia who have a background of Christianity with a brief Bible lesson about the life of Jesus. I will utilize three different methods (1) a traditional Bible study similar to one many pastoral visitors give (2) a Bible lesson using a book I have created with large print verses and objects to touch (3) a Bible lesson using a basket of objects, such as a wooden cross, a lamb, etc., to stimulate memory.

I will spend approximately 15 minutes each time I visit, for a total of three visits. The reaction to each ministry style will be noted by my assistant. I will be able to determine which method is most useful and which of the methods best evoke spiritual memory.

You may review my materials at any time, and I will answer any questions you have about the research. You may also contact my advisors at Oxford Graduate School, Dr. Helen Morgan or Dr. Ted Kittell, at 775-6596.

Names of all participants will be confidential. Your resident can help make a significant contribution to this study and to the spiritual welfare of others who suffer from dementia. I appreciate your signature on the attached consent form.

Sincerely,

Diana Walters

APPENDIX 7

CONSENT FORM

CONSENT FORM

I, _____, give permission for _____ to participate in a study that looks at three methods of ministry to people with dementia. Three Bible lessons will be given, and the participants reaction to the lesson will be observed and recorded by a trained observer. The study will take place in the facility in which the resident resides. I understand that names of participants will be kept confidential.

Signature_____ Date_____

APPENDIX 8

OBSERVED EMOTION RATING SCALE

OBSERVED EMOTION RATING SCALE

RESIDENT'S NAME _____ UNIT: _____ OBSERVER'S NAME: _____ DATE: _____ TIME:_____

Please rate the extent or duration of each affect over a ten-minute period. Some possible signs of each emotion are listed.
If you see no sign of a particular feeling, rate "Never."

		7	1	2	3	4	5
		Not in view	Never	Less than 16 sec.	16-59 sec.	1-5 min.	more than 5 min.
PLEASURE Signs: Laughing; singing; smiling; kissing; stroking or gently touching other; reaching out warmly to other; responding to music (**only** counts as pleasure if in combination with another sign).							
ANGER Signs: Physical aggression; yelling; cursing; berating; shaking fist; drawing eyebrows together; clenching teeth; pursing lips; narrowing eyes; making distancing gesture.							
ANXIETY/FEAR Signs: Shrieking; repetitive calling out; restlessness; wincing/grimacing; repeated or agitated movement; line between eyebrows; lines across forehead; hand wringing; tremor; leg jiggling; rapid breathing; eyes wide; tight facial muscles.							
SADNESS Signs: Crying; frowning; eyes drooping; moaning; sighing; head in hand; eyes/head turned down and face expressionless (**only** counts as sadness if paired with another sign).							
GENERAL ALERTNESS Signs: Participating in a task; maintaining eye contact; eyes following object or person; looking around room; responding by moving or saying something; turning body or moving toward person or object.							

APPENDIX 9

PRINTOUT FROM WINKS ANALYSIS OF EFFECTS OF ORDER

PRINTOUT FROM WINKS ANALYSIS OF EFFECTS OF ORDER

```
WINKS 4.62                                                    June 29,2004
------------------------------------------------------------------------
Repeated Measures Analysis Summary                          C:\ORDER.DBF
------------------------------------------------------------------------
Number of repeated measures is  3
Number of subjects read in  24

Means and standard deviations for  3  repeated measures:
 1)FIRST: mean = 266.04167        s.d. = 222.41998
 2)SECOND: mean = 172.625         s.d. = 166.11934
 3)THIRD: mean = 212.625          s.d. = 227.68472


   Repeated Measures Analysis of Variance

   Source              -----S.S.-----  --DF--   MS          F     Appx p
   ------------------------------------------------------------------------
Between Subject         1380064.00      23
Within Subject          1690228.00      48
  Rep. Factor     105440.10           2     52720.05      1.53    0.227
  Error            1584788.          46     34451.91
------------------------------------------------------------------------
Total                   3070292.00      71

Error term used for comparisons = 34,451.91 with 46 d.f.

                                                              Critical S
  Scheffe Multiple Comp.           Difference         S          (.05)
------------------------------------------------------------------------
    Mean(FIRST)-Mean(SECOND) =       93.4167        1.743        2.53
    Mean(FIRST)-Mean(THIRD) =        53.4167  (Do not test)
    Mean(THIRD)-Mean(SECOND) =       40.0000  (Do not test)

Homogeneous Populations, repeated measures ranked

Gp  1  refers to FIRST
Gp  2  refers to SECOND
Gp  3  refers to THIRD

               Gp  Gp  Gp
                2   3   1
               -----------

This is a graphical representation of the Scheffe's multiple comparisons test.
At the 0.05 significance level, the means of any two groups underscored by the
same line are not significantly different.
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APPENDIX 10

PRINTOUT FROM WINKS ANALYSIS OF EFFECTS OF OBSERVER

PRINTOUT FROM WINKS ANALYSIS OF EFFECTS OF OBSERVER

```
WINKS 4.62                                                        June 29,2004
------------------------------------------------------------------------------
Repeated Measures Analysis Summary                      C:\WINKS\ARTR1.DBF
------------------------------------------------------------------------------
Number of repeated measures is  3
Number of subjects read in  12

Means and standard deviations for  3  repeated measures:
 1)KG: mean = 405.0              s.d. = 184.71107
 2)SH: mean = 260.0              s.d. = 282.97125
 3)MK: mean = 260.0              s.d. = 285.27499


Repeated Measures Analysis of Variance

Source              -----S.S.-----  --DF--      MS          F     Appx p
------------------------------------------------------------------------------
Between Subject         1162700.00      11
Within Subject          1156800.00      24
  Rep. Factor     168200.00           2     84100.00      1.87  0.178
  Error           988600.00          22     44936.36
------------------------------------------------------------------------------
Total                   2319500.00      35

Error term used for comparisons = 44,936.36 with 22 d.f.

                                                                  Critical S
  Scheffe Multiple Comp.           Difference          S            (.05)
------------------------------------------------------------------------------
    Mean(KG)-Mean(SH) =                145.0         1.676        2.627
    Mean(KG)-Mean(MK) =                145.0   (Do not test)
    Mean(MK)-Mean(SH) =                  0.0   (Do not test)

Homogeneous Populations, repeated measures ranked

Gp  1  refers to KG
Gp  2  refers to SH
Gp  3  refers to MK

               Gp  Gp  Gp
                2   3   1
               -----------

This is a graphical representation of the Scheffe's multiple comparisons test.
At the 0.05 significance level, the means of any two groups underscored by the
same line are not significantly different.
```

APPENDIX 11

PRINTOUT FROM WINKS ANALYSIS OF INTERACTION BETWEEN TREATMENT AND AFFECT

PRINTOUT FROM WINKS ANALYSIS OF INTERACTION BETWEEN TREATMENT AND AFFECT

```
WINKS 4.62                                                    June 29,2004
------------------------------------------------------------------------------
Repeated Measures Analysis Summary                  C:\WINKS\DIAAFFECT.DBF
------------------------------------------------------------------------------
Number of repeated measures is  3
Number of subjects read in  24

Means and standard deviations for  3  repeated measures:

 1)TRAD: mean = 63.08333          s.d. =  96.30654
 2)BOOK: mean = 336.91667         s.d. = 195.77824
 3)OBJECTS: mean = 261.79167      s.d. = 210.38763


Repeated Measures Analysis of Variance

Source              -----S.S.-----  --DF--      MS          F     Appx p
------------------------------------------------------------------------------
Between Subject         1307733.00      23
Within Subject          1766116.00      48
  Rep. Factor     960907.70           2    480453.80     27.45    <.001
  Error            805208.2          46     17504.53
------------------------------------------------------------------------------
Total                   3073849.00      71

Error term used for comparisons = 17,504.53 with 46 d.f.

                                                                  Critical S
  Scheffe Multiple Comp.           Difference         S            (.05)
------------------------------------------------------------------------
    Mean(BOOK)-Mean(TRAD) =         273.8334          7.17         2.53 *
    Mean(BOOK)-Mean(OBJECTS) =        75.125         1.967        2.53
    Mean(OBJECTS)-Mean(TRAD) =      198.7084         5.203        2.53 *

Homogeneous Populations, repeated measures ranked

Gp  1  refers to TRAD
Gp  2  refers to BOOK
Gp  3  refers to OBJECTS

               Gp Gp Gp
                1  3  2
                  ------
               ---

This is a graphical representation of the Scheffe's multiple comparisons
test. At the 0.05 significance level, the means of any two groups
underscored by the same line are not significantly different.
```

APPENDIX 12

PRINTOUT FROM WINKS ANALYSIS OF INTERACTION BETWEEN TREATMENT AND ALERTNESS

PRINTOUT FROM WINKS ANALYSIS OF INTERACTION BETWEEN TREATMENT AND ALERTNESS

```
WINKS 4.62                                                    June 29,2004
------------------------------------------------------------------------
Repeated Measures Analysis Summary                  C:\Di622ALERT.DBF
------------------------------------------------------------------------
Number of repeated measures is  3
Number of subjects read in  24

Means and standard deviations for  3  repeated measures:
 1)TRAD: mean = 462.5            s.d. = 162.62119
 2)BOOK: mean = 587.5            s.d. =  35.2938
 3)OBJECTS: mean = 557.5         s.d. = 124.45534

Repeated Measures Analysis of Variance

Source              -----S.S.-----  --DF--      MS           F     Appx p
------------------------------------------------------------------------
Between Subject          506350.00      23
Within Subject           691200.00      48
  Rep. Factor     204400.00          2        102200.00     9.66    <.001
  Error             486800.         46         10582.61
------------------------------------------------------------------------
Total                   1197550.00      71

Error term used for comparisons = 10,582.61 with 46 d.f.

                                                              Critical S
  Scheffe Multiple Comp.           Difference         S          (.05)
-------------------------------------------------------------------------
    Mean(BOOK)-Mean(TRAD) =            125.0         4.209        2.53 *
    Mean(BOOK)-Mean(OBJECTS) =          30.0         1.01         2.53
    Mean(OBJECTS)-Mean(TRAD) =          95.0         3.199        2.53 *

Homogeneous Populations, repeated measures ranked

Gp  1  refers to TRAD
Gp  2  refers to BOOK
Gp  3  refers to OBJECTS

               Gp  Gp  Gp
                1   3   2
                    -------
               ---

This is a graphical representation of the Scheffe's multiple comparisons test.
At the 0.05 significance level, the means of any two groups underscored by the
same line are not significantly different.
```

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