

# The Lived Experience of Dementia: Developing a Contextual Theology

## Abstract

A variety of themes are explored as the basis for developing a contextual theology of dementia. These include impairment, loss, dislocation, isolation, decline and death. These themes represent immanent human concerns with various kinds of experiences of “self-emptying”. It is suggested that dementia presents a kind of “malaise of immanence”, within which there is progressive inability to focus on abstract transcendent concerns, and increasing preoccupation with the immediate immanent context. A contextual theology of dementia which exaggerates the importance of the immanent frame is likely to emphasise, and draw to our attention, concern about such things within that frame as cognitive decline, dependence upon others for care, and loss of hope. However, a Christological perspective is offered within which it is acknowledged that such places of self-emptying are also places of transcendent encounter, and that in Christ we may understand the participation of God in the darkest moments of human experience

## Introduction

What might it mean to develop a theology that is contextual to the lived experience of dementia? The concept of contextual theology arose from a recognition that theology is influenced by the context within which it originates (Bergmann, 2003; Bevans, 2002; Pears, 2010). Contextual theology provides an interpretation of the experience of that context, but is also itself interpreted (or re-interpreted) by the context. It arguably also has a particular concern with the interpretation of, and commitment to, praxis (Bevans, 2002, pp. 70-87). The whole idea that there might be such a thing as a contextual theology of dementia therefore implies that the experiences of living with dementia (as sufferer or carer) or working with dementia (as health professional) both require and provide theological interpretation. On the one hand, there is a need to reflect theologically on the experience of dementia, and on the other hand there is a need to reflect on our theology in the light of these same experiences. And this bi-directional reflection is important because it opens up new possibilities for practice, causing us to re-evaluate our norms and values.

The “context” of contextual theology has traditionally been understood in terms of culture, ethnicity, gender and politics rather than mental health. A theology contextual to dementia might therefore have to engage with multiple other contextual considerations in addition to that of the condition itself. We cannot assume that the lived experience of dementia is the same for men and women, for black and Caucasian, for rich and poor, or for people in both the global north and south. However, within each of these contexts, we might imagine that the experience of dementia will impose its own influence on the way in which we do our

theology, and that theology in turn might have some more or less consistent things to say which will inform our understanding of the experience in question. Thus the present essay, from the situated perspectives of its own author, with all their limitations, seeks to explore some of these bi-directional influences, in order that they might be further explored by others in other contexts.

Any attempt at developing a contextual theology of the lived experience of dementia will require that we have a “thick description” (Geertz, 1973, pp. 3-30) of that experience upon which, and from which, to engage in reflection. A description of this kind would, ideally, include the perspectives available from a range of social and human sciences, as well as the personal narratives of those who suffer from dementia, and those who care for them. Indeed, I take it that any theology of “lived experience” will especially focus on those most directly engaged in and with the experience.

A thick description of this kind cannot fully be provided in a single chapter such as this. Indeed, it is arguably beyond the scope of any individual human being – for it would require expertise in a range of scientific disciplines, as well as personal, professional and other lived experience of the nature of dementia. Happily, much of this thick description will be filled out in more detail in other parts of the present book, and in other books. However, taking what we might consider to be a basic medical description of dementia, a number of things will immediately become apparent, and it is from this perspective that I shall start. It is not the only possible starting point, or even necessarily the best one, but it is the one that has most authenticity for a writer who has worked for much of his life in the health service and who draws on past clinical and pastoral experience as the context for writing.

## **Dementia: The clinical and scientific context<sup>1</sup>**

The group of conditions referred to as the dementias are characterised by cognitive impairments, including amnesia, aphasia, agnosia and apraxia.<sup>2</sup> However, the impairments experienced by the person suffering from dementia are not limited to the cognitive domain. They include also functional impairments (inability to undertake activities of daily living), mood disorder, psychosis, personality change and behaviour change. The devastating

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<sup>1</sup> It will not be possible to present a detailed or comprehensive account here. The interested reader is referred to standard textbooks of psychiatry, such as *The New Oxford Textbook of Psychiatry* ((Gelder, López-Ibor, & Andreason, 2004)).

<sup>2</sup> Amnesia is an impairment of memory – often a presenting feature of dementia. Aphasia is an impairment of language function. Agnosia is an impaired ability to understand and interpret the significance of perceived stimuli (in the presence of intact neural pathways enabling normal perception). Apraxia is an impaired ability to perform constructive intentional acts (despite intact neural pathways).

consequences of this wide ranging impairment, for the person concerned, include loss of independent living, vulnerability to accident and abuse, loss of dignity, stigma, discrimination and distress. There is a similarly wide range of distressing consequences for carers, family and friends who often report the “loss” of the person whom they love well in advance of the physical death of that person, and yet who find that their lives are changed radically by the responsibilities of caring for the person while they are still alive.

Whilst this, very brief, outline description of the clinical picture of dementia might imply some kind of uniformity of presentation, there are in fact a number of underlying causes of dementia, that is, there are a range of different dementias. Whilst Alzheimer’s disease and multi-infarct dementia (MID) are much the commonest, we must note also the existence of fronto-temporal dementia, prion<sup>3</sup> disease (Jacob-Creutzfeld dementia), Lewy<sup>4</sup> body dementia, and HIV associated dementia, amongst others. Not only are the clinical presentations of these conditions varied, but the context that each provides for the person concerned has very different implications. One dementia is not the same as another.

Thus, for example, we might note the general course of progression of Alzheimer’s disease, over a period of some 5 to 10 years, associated with gradually declining mental and physical functioning and the eventual, inevitably fatal, outcome. This typically contrasts with the more stepwise and fluctuating progression of MID, as each new vascular episode leads to the death of a new region of brain tissue, bringing its own additional deficits (eg motor paralysis) and adding to the overall decline. MID is usually fatal within a shorter time span than Alzheimer’s disease, as is Lewy body dementia. In prion disease the course of the illness can be very brief, or last as long as 20 years, although it also is inevitably fatal in the end.

Just as the clinical course varies, so does the age of onset. Alzheimer’s disease typically presents, initially with minor impairment of memory, after the age of 70. MID often has a more acute onset, with emotional and personality change preceding memory impairment. Fronto-temporal dementia, in contrast seldom presents after the age of 70 and may be seen in the late 30s. Early signs include loss of personal and social awareness, such that self-care may be neglected and behaviour interpreted as anti-social.

In addition to this varied clinical presentation, the context of the diagnosis is very different from one condition to another. MID is typically associated with other evidence of vascular disease, such that the person with MID may also be living with the consequences of heart disease or peripheral vascular disease (such as the difficulties with walking caused by poor arterial circulation in the legs). The person with HIV associated dementia will be living with

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<sup>3</sup> Prions are abnormal proteins found in the brains of affected people and animals, by means of which the disease may be spread.

<sup>4</sup> Lewy bodies are characteristic laminated, spherical structures seen within the nerve cells of the brains of sufferers – although they are also found in the brains of some normal elderly people, and in people suffering from other forms of dementia.

all the serious implications, stigma and fear associated with this diagnosis, including perhaps a range of secondary infections, malignancy and the psycho-social context of the relationship (loving, abusive, drug using or otherwise) within which the infection was acquired. In conditions such as HIV dementia, or prion disease, there may be anger, or guilt, concerned with perceived responsibility for acquiring/transmitting the infection. In some cases, there may be fear that the condition will be inherited by others in the family.

For most of the conditions that we are considering here there is currently no effective cure. Treatment is aimed at providing psychological and social support for the person with dementia and their family. Whilst medication, and psycho-social interventions, may improve quality of life in the short-term, it is generally not possible to alter the eventual outcome. There is thus a protracted process of coming to terms with things, both for the person affected and their family and friends. Whilst the person affected may increasingly lose insight into the implications of all of this, a loss which often makes the whole experience even more bewildering and isolating, family and carers are faced with increasingly demanding responsibilities of care and protection from harm.

In the face of this immense challenge, the focus is now on patient-centred care (National Institute for Health and Clinical Excellence & Social Care Institute for Excellence, 2006). Within this approach, the unique value of the person as a human being in relationship with others is affirmed, whatever their state of cognitive decline. The importance of early diagnosis, integration of social and health care, and provision of good quality specialist services are all emphasised. The general aim is to enable people to live independently as long as possible, and to minimise as much as possible the impact of cognitive decline, affective disorder and challenging behaviour (including agitation and aggression) by use of a variety of pharmacological and non-pharmacological interventions. From the point of diagnosis, consideration should be given to planning for end of life care, in order that the person suffering from dementia may die with dignity and with the support and comfort of those who love them.

The context of dementia is thus a complex and challenging one – with differing and varied implications for each individual depending upon the exact diagnosis, the particular clinical presentation, the progression of the condition, and the extant social and family relationships.

## **Themes**

A number of themes emerge from a consideration of the nature and experience of dementia. Most obviously, the dementias are conditions associated with impairment and loss of a wide range of mental faculties, including those which are amongst the most fundamental to our very experience of being human. At this point, it is important to highlight that the experience of being human and the “being” of being human, are not at all the same thing. However, the loss and impairment of abilities to reason, relate, perform basic tasks of daily life, and to experience emotions appropriate to the situation are basic

and significant enough both to represent a profound challenge to our understanding and interpretation of life and, at the same time, to impair our ability to cope with and respond effectively to this challenge. But loss and impairment are not the only themes that are challenging within the lived experience of dementia.

Whilst cognitive and affective functioning is impaired, there is also a certain “dislocation of attention”, from those things that normally and properly concern us to other things. This dislocation occurs in a variety of ways. Cognitively, it is a result of impaired memory and other processes such that attention is diverted from the present realities and concerns of life either to past events, which then inappropriately preoccupy present attention, or else to present matters which would not normally be a cause for concern. Perceptually, this dislocation of attention may be further impaired (at least in some cases) by hallucinations which distort the experience of present reality.

As a result of the impact of symptoms on ability to relate to those around, and also often a variety of social factors including stigma, ignorance and fear, and sometimes even despite the best efforts of family and professionals to the contrary, the person with dementia is isolated from those around them. This isolation can be painful for family and friends, as well as for the person herself. As if this were not enough to deal with, family and carers, if not the person concerned, live with the knowledge that the inevitable course of dementia (in the vast majority of cases) will be one of decline and eventual death.

The themes that I have identified here: impairment, loss, dislocation, isolation, decline and death, are all psychologically significant and have important theological associations. Any or all of them might be the focus of important theological reflections which deserve attention well beyond the scope of the present essay. Neither, although I think they are important and salient concerns, are they the only themes that might be identified as worthy of theological reflection. However, I think that they offer enough to orientate us towards some of the contextual theological tasks that lay before us.

### **Theological Engagement**

Whilst it is probably fair to say that relatively little theological attention has been given to the topic of dementia hitherto, there have been some important studies that are worthy of attention, some of which will be mentioned here.

Firstly, empirical, longitudinal, research undertaken by Kaufman et al (2007) shows that self-rated spirituality and private religious practices appear to be associated with slower decline of cognitive functioning in people with a diagnosis of Alzheimer’s disease. Whilst these are only preliminary findings, in a relatively small sample (n=70), they are consistent with findings in other disease states and they suggest that there is an important place for further empirical research in this field. Theological engagement thus potentially has a very practical edge, informing the nature and content of psychosocial interventions, as well as a more obviously “spiritual” dimension.

Secondly, a variety of writers and researchers have addressed the way in which the personhood of the man or woman with dementia is variously misunderstood as either lost or impaired. Based upon the findings of empirical, qualitative research, Harriet Mowatt has drawn attention to the importance of maintaining a person centred focus on the person with dementia as a person in relationship (Mowatt, 2011). Also related to the theme of personhood, and drawing on both his clinical experience and philosophical reflection, Julian Hughes has described a “SEA” (Situating Embodied Agent) model of personhood (Hughes, 2011). Both of these writers importantly inform our understanding of what it is to be a person with dementia and also are able to draw conclusions with relevance to clinical practice. Again, the findings of empirical research, and accepted standards of clinical practice concerning the importance of psycho-social interventions, here coincide with important theological and philosophical themes concerning the nature of personhood in relationship.

Thirdly, John Swinton has drawn attention to the importance of “present moment” spirituality for the experience of the person with dementia (Swinton, 2011). Suggesting that we need to re-think our understanding of time, and to recognise that God has redeemed time, Swinton suggests that time is meaningful and that spending time with someone who suffers from dementia thus has meaning and purpose. This is a theme to which we shall return shortly.

Fourthly, and importantly for Christian theology, Peter Kevern has suggested that the experience of Jesus on the cross might be understood as a kind of dementia (Kevern, 2009). Whilst this is not strictly medically correct (as the confusional state associated with severe trauma of this kind would be diagnosed as an acute organic syndrome rather than as a dementia) this helpfully draws our attention both to the vulnerability of the human condition, especially here in terms of mental functioning, and the sharing of God in this vulnerability and suffering in Christ. This does not necessarily make the vulnerability and suffering associated with dementia easier to understand or manage, but it offers a Christological perspective upon the experience with important implications for both theodicy and spirituality. Together with Swinton’s understanding of time itself as meaningful, it gives us cause to hope that meaning can be found amidst the otherwise apparently meaningless suffering of dementia.

Any, and all, of these previous theological engagements with the lived experience of dementia offer promising opportunities for building the kind of contextual theology that is the topic of this essay, and some of them will be taken up again later on. However, the scope of the present argument will be limited to outlining a contextual theology within which reflections might be offered upon and from a perspective of Christian spirituality. The intention is both to gain understanding of what (some of) the spiritual challenges are of living with the experience of dementia, and also to reflect upon what the lived experience of dementia teaches us about spirituality. Although reference will primarily be to Christian spirituality, the importance of engaging with diverse traditions of spirituality, such as are commonly encountered in plural and secular western societies, will also be kept in mind.

## **Immanence, transcendence, and dementia**

I have argued elsewhere (Cook 2013, *in press*) that the theological concepts of transcendence and immanence offer important opportunities for theological engagement with mental health and disorder. This arises in part because of the research evidence base which is accumulating in regard to the importance of spirituality and religion in healthcare as protective factors which are associated in many cases with reduced morbidity and mortality, better coping, and improved outcomes following treatment (Koenig, King, & Carson, 2012). Within this body of evidence, both spirituality and religion are usually understood in some way in relation to the transcendent.

Crude understandings of spirituality as concerned with the transcendent, in such a way as to oppose spirituality to the immanent domain, are not helpful. Properly understood, at least according to the Christian tradition, the transcendent is in a dynamic and integral relationship with the immanent order and is not an alternative way of conceiving of reality, but rather a dimension of understanding reality which should not be neglected or excluded. Nor is this an impersonal aspect of our understanding of the world and of the human condition. At least, it will not be so for Christians, although it might be so conceived within other traditions (such as Buddhism). In fact, one advantage of the language of transcendence and immanence is that it offers a common vocabulary for discourse between diverse traditions, including the secular conceptions of spirituality common in healthcare, whilst at the same time being easy for Christians to translate into personal, Christological and incarnational language.

However, I believe that immanence and transcendence are also important concepts within the field of mental health for other reasons, and perhaps especially so for our consideration here of the group of conditions known as the dementias. Charles Taylor, in *A Secular Age*, has written about the “malaise of immanence” that he understands as an affliction of contemporary western society (Taylor, 2007). This malaise arises as a result of the present over-emphasis on the immanent frame of reference that is constituted by scientific, social, technological, epistemological and other “structures” within which life is habitually understood, publically spoken about and lived. It is a natural, “this-worldly” order of things, understood on its own terms without reference to a transcendent order. Indeed, it is biased against transcendence. In this context, the malaise of immanence arises as a reaction to structures of thinking that are closed to transcendence.

The malaise of immanence, according to Taylor, is characterised by fragility of meaning, loss of transcendence, the cross pressured self, a loss of solemnity in life transitions, and an experience of flatness and emptiness of the ordinary. Meaning becomes fragile by virtue of the way in which each individual is encouraged to find their own meaning in life and at the same time to respect the meanings that others find as equally valid, even where mutually contradictory. Thus meaning itself becomes, as Taylor calls it, “fragile”. In response to the

loss of shared transcendent reference, associated by Taylor with traditional religion, Taylor describes a “nova effect” whereby new sources of transcendence are sought, either by a return to traditional religious structures, or else in a very subjective, personal and individual way. It is this diversity of available sources of transcendence that provides cross-pressured influences upon the self that seeks transcendent reference, drawing it in different and competing directions (new and traditional). Life is experienced as flat and empty without transcendence, and yet the quest for transcendence encounters a bewildering array of mutually invalidating sources of potential meaning.

It is in this social context that spirituality has become a preferred, increasingly referenced, and yet deeply controversial concept in the healthcare context (Cook, 2010, 2012; Cook, Dein, Powell, & Egger, 2010; King & Leavey, 2010). In fact, there are spiritual practices which are predominantly concerned with the immanent domain and any caricature of either spirituality or religion as associated with an understanding of transcendence crudely opposed to immanence is both simplistic and inadequate (Cook 2013, *in press*) and does not do justice to the subtlety and complexity of Taylor’s argument. However, the importance of Taylor’s concept of a malaise of immanence has more relevance here than simply providing a contextual account of immanence and transcendence in contemporary western society.

In certain important ways, dementia produces its own malaise of immanence at the individual level. The person who suffers from one of the dementias might often be understood as imprisoned within an immanent frame of reference. Not that the present moment is experienced by such a person in objectively scientific ways, or that the perceptual sources of reference are always accurate and reliable, but rather that the capacity for complex, “transcendent” and self-reflective thought is impaired and – eventually – largely lost. Similarly, the ability to find and evaluate reliable and valid sources of meaning is impaired and lost. Cross pressures upon the self, and the importance of such events as life transitions, are increasingly incomprehensible, impossible to evaluate, bewildering and confusing. Everyday life becomes flat and ordinary at best, frightening and overwhelming at worst.

This individual malaise of immanence, afflicting the person with dementia, should not be taken as implying that in fact “this is all there is”. It reflects an increasing limitation of cognitive capacity at an individual level in the case of dementia, in a not dissimilar way to the increasing restrictions upon capacity for transcendent discourse at a social level in the case of Taylor’s account of secular society. It is a restriction upon ways of understanding things, not a restriction of things themselves. I also recognise that the parallels are limited and that what I am describing as the malaise of immanence in dementia, resulting primarily from neurodegenerative processes, is very different in significant ways from the secular malaise of immanence that Taylor describes, resulting from social and epistemological processes. For example, the inevitable decline and disorder of cognitive functioning characteristic of dementia do not have true equivalents in Taylor’s social malaise of immanence (although I think a certain decline within society over a particular period in history is probably implicit in Taylor’s account). However, I suggest that it yet provides a helpful way for engaging with a contextual theology of the lived experience of dementia.

A contextual theology of dementia which exaggerates the importance of the immanent frame is likely to emphasise, and draw to our attention, concern about such things within that frame as cognitive decline, dependence upon others for care, and loss of hope. These are, of course, not unimportant considerations, and they reflect a certain reality, but attention to these concerns at the expense of other things might be expected to emphasise the sense of loss and impairment and exacerbate the malaise of immanence. Equally, an exaggerated sense of the transcendent frame might be expected to emphasise a spirituality divorced from present reality, and devalue the importance of the present moment. Ultimately, one might expect that this would lead to dualism – an understanding of continued bodily existence within which (or perhaps separated from which) continued spiritual life is imprisoned and disconnected from immanent physical reality.

In fact, I would suggest, a contextual theology of the lived experience of dementia should aspire to maintain a dynamic integrity of immanent and transcendent perspectives. This may not always be easy to do, but I think that it represents the only way to be true to both the observed immanent realities of dementia and the fundamental transcendent concerns of spirituality and faith. Moreover, for Christians, it provides a crucial link between the human experiences of loss, decline and depletion that are so characteristic of dementia and the self-emptying humanity of Christ, within which (paradoxically) humanity is fully expressed and the transcendent – God – is revealed.

### **Kenosis, Self-Emptying and Christian Theology**

Kenosis is a concept of the self-emptying of Christ, and thus (according to Christian doctrine) of God in Christ, the foundation for which is usually understood as being based primarily upon a passage written by Paul of Tarsus in his letter to the Philippians, probably around 59-61 CE:

Let the same mind be in you that was in Christ Jesus, who, though he was in the form of God, did not regard equality with God as something to be exploited, but emptied himself, taking the form of a slave, being born in human likeness. And being found in human form, he humbled himself and became obedient to the point of death-- even death on a cross.<sup>5</sup>

The basis for kenosis within this early text might be deceptive, and it would appear that the doctrine is in fact largely one of modern times (Baillie, 1955, pp. 94-95). However, as Hawthorne notes (1983, pp. 85-86), the attribution of the self-emptying to refer to divine attributes, apart from lack of textual support, is unnecessary. Christ can simply be understood (according to the Pauline text) as humanly pouring himself out for others. Paradoxically, this pouring out takes the form of taking on – taking on the form of a slave, taking on human form, and taking on human likeness. Importantly, this understanding

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<sup>5</sup> Philippians 2:5-8, New Revised Standard Version

actually makes the concept more rather than less relevant for our present purpose. If we understand dementia as, in some way, as an “emptying out” of some of the important aspects of what it is to be human, yet without loss of that humanity (indeed, perhaps even as an expression of that humanity) then we have an important point of contact between our thick description of dementia and Christian understanding of an important aspect of the incarnation. In being emptied of things that are important to our humanity, we actually demonstrate our humanity and – at least potentially – we draw closer to the experience of Christ in his humanity.

If kenosis is a modern doctrine, then it is one that has made contact with some important strands of recent Christian thinking. For example, feminist theology finds here an emptying of (patriarchal) power (Cooey, 1996), and liberation theology finds a taking on of human poverty (Gutierrez, 1985, p. 300). Similarly, we might understand Christ on the cross (as Kevern suggests) emptying himself of clear and rational thought, and even if Christ did not actually suffer dementia (as it would appear that he did not) then still we can see him as taking on a human nature which was vulnerable to such a neurodegenerative process, and as taking on a poverty of both a literal and metaphorical kind which is evocative of the mental poverty that characterises the immanent account of dementia.

The themes that emerge from our “thick description” of dementia, then, impairment, loss, dislocation, isolation, decline and death, are closely related to, or at least evocative of, some of those that we find emerging from Christian reflection upon the incarnation of Christ and the passion narratives. Just as Christian reflection upon the passion of Christ incorporates both immanent (human) and transcendent (divine) perspectives, so our reflection upon the lived experience of dementia should properly incorporate not only an immanent account of loss and decline, but also a transcendent account of the participation of God in the darkest moments of human experience.

### **Towards a Contextual Theology of Dementia**

The building of a contextual theology, then, will require both a “thick” description of the immanent reality of the condition and also a “thick” account of the nature of transcendent reality which is neither reducible to psychological variables nor crudely supernatural or dualistic. We might approximately translate this to mean that we need a fully informed scientific account of the condition allied to an intelligent theological account, but I am reluctant to concede this as an adequate translation of what I am saying. Immanent realities provide the context within which theophanies are perceived, and transcendent realities provide the context for understanding and interpreting immanent experience. Neither can adequately (“thickly”) be described without taking the other into account, and each is interwoven with the other. Immanent and transcendent reality in their properly sophisticated, dynamic and integral, relationship with each other provide a seamless whole which is not adequately described by separating out the one from the other.

Our theological reflection upon the context of the lived experience of dementia, then, might lead us to expect that something of the Divine might be encountered amidst this experience. Our brief reflection upon the self-emptying of Christ gives us a basis, in the New Testament, for imagining how we can understand this to be so. John Swinton's proposal that we look to the Christian tradition of "present moment" spirituality suggests something of how we can make this to be so – for suffering is not a virtue in itself (Hauerwas, 1988, pp. 32-33) and the experience of dementia will not, in itself, be meaningful unless it is interpreted as such. In the present context, this offers an especial challenge for the person with dementia who may well lose the cognitive capacity to make such interpretations although, within each present moment, there is likely to be some possibility of such a thing, however limited or dislocated (in immanent terms) it may be.

We noted at the outset of this essay that contextual theology is, at least potentially, a bidirectional process. What, then, does our thick description of this condition offer by way of response back to the contextual theologian? How might it make our theology look different? I can imagine a variety of ways in which this conversation might proceed, and I do not pretend to have transcribed the entire dialogue here. However, I think that one important response will be that the extent of our capacity to discern the transcendent amidst the immanent cannot be entirely dependent upon cognitive capacity.

In one sense, we already know this. Denys Turner, for example, in writing about the darkness of God, reminds us that there is a dialectic of mystical encounter with God, within which divine light is experienced as darkness, and knowing turns out to be unknowing. Such is the gulf between immanent human experience and divine transcendence that our best light is darkness, and our highest knowledge is ignorance (Turner, 1999, pp. 17-18). However, anchored in this context of academic reflection upon the writings of Plato and Gregory of Nyssa, it would be easy to imagine that we can still be quite proud of what we know. The lived experience of dementia behoves us to greater humility than this, for it reminds us that our richest and our poorest moments of human knowing are alike darkness in comparison with the light of divine knowledge. Moreover, it encourages us to think again about whether there is a gulf between God and human beings, between the transcendent and the immanent, at all. For, if there is, how can human beings (suffering from dementia or not) ever encounter God? Rather, we are reminded that our theology must allow for an encounter of the immanent and transcendent, in inseparable and dynamic engagement with each other, within each present moment, as a matter of divine grace which is not contingent upon our cognitive capacity.

A contextual theology of dementia also provides some important points of contact with the secular age in which we live (so that it is not divorced from realities about which we can meaningfully speak to others). I think that the language of immanence and transcendence allows us this dialogue within a common framework that both encourages Christians to explore the Christological core of their theology, but also does not deny the possibility of finding common ground with those of others faiths (within some of which transcendence will not be understood in personal terms). It also draws attention, I hope, to the ways in

which we all suffer from a “malaise of immanence”, and that these matters are therefore of concern to us all.

## Conclusion

A contextual theology of dementia, or at least the quest to develop such a theology, presents us with some humbling realities. Human nature is vulnerable to processes of self-emptying which take us to places within which we seem to lose the things that we most associate with our experience of being human, and yet in these places we potentially find our humanity brought most clearly into focus. When we are most reduced to the limits of immanent experience, there we find ourselves no less close to transcendent encounter. Immanent and transcendent accounts of human experience, including the lived experience of dementia, are only adequately understood (if they can be adequately understood at all) not as polarised alternatives, but as existing in an inseparable tension. Thus, within each present moment of the lived experience of dementia, the possibility of a transcendent encounter remains.

## References

- Baillie, D. M. (1955). *God was in Christ* (2nd ed.). London: Faber & Faber.
- Bergmann, S. (2003). *God in Context: A Survey of Contextual Theology*. Aldershot: Ashgate.
- Bevans, S. B. (2002). *Models of Contextual Theology* (Revised ed.). Maryknoll: Orbis.
- Cooley, P. M. (1996). Kenosis. In L. M. Russell & J. S. Clarkson (Eds.), *Dictionary of Feminist Theologies* (pp. 163). London: Mowbray.
- Cook, C. C. H. (2010). Spirituality, secularity and religion in psychiatric practice. *The Psychiatrist*, 34(5), 193-195.
- Cook, C. C. H. (2012). Self-belief: holistic psychiatry in a secular age. Commentary on... Holistic Psychiatry without the whole self. *The Psychiatrist*, 36(3), 101-103.
- Cook, C. C. H., Dein, S., Powell, A., & Egger, S. (2010). Spirituality and Boundaries in Psychiatry. *The Psychiatrist*, 34(6), 257-258.
- Geertz, C. (1973). *The Interpretation of Cultures: Selected Essays*. New York: Basic Books.
- Gelder, M. G., López-Ibor, J. J., & Andreason, N. C. (2004). *New Oxford textbook of psychiatry* (Vol. 1 & 2). Oxford: Oxford.
- Gutierrez, G. (1985). *A Theology of Liberation*. London: SCM.
- Hauerwas, S. (1988). *Suffering presence*. Edinburgh: T&T Clark.
- Hawthorne, G. F. (1983). *Philippians*. Waco: Word.
- Hughes, J. C. (2011). A Situated Embodied View of the Person with Dementia. Where does the Spiritual come in? In A. Jewell (Ed.), *Spirituality and Personhood in Dementia* (pp. 198-206). London: Jessica Kingsley.

- Kaufman, Y., Anaki, D., Binns, M., & Freedman, M. (2007). Cognitive decline in Alzheimer disease: Impact of spirituality, religiosity, and QOL. *Neurology*, *68*, 1509-1514.
- Kevern, P. (2009). Sharing the mind of Christ: preliminary thoughts on dementia and the Cross. *New Blackfriars*, *91*, 408-422. doi: DOI:10.1111/j.1741-2005.2009.01317.x
- King, M., & Leavey, G. (2010). Spirituality and Religion in Psychiatric Practice: Why all the Fuss? *The Psychiatrist*, *34*, 190-193.
- Koenig, H. G., King, D. E., & Carson, V. B. (2012). *Handbook of Religion and Health* (2nd ed.). New York: Oxford University Press.
- Mowat, H. (2011). Voicing the Spiritual: Working with People with Dementia. In A. Jewell (Ed.), *Spirituality and Personhood in Dementia* (pp. 75-86). London: Jessica Kingsley.
- National Institute for Health and Clinical Excellence, & Social Care Institute for Excellence. (2006). *Dementia: Supporting people with dementia and their carers in health and social care*. London: National Institute for Health and Clinical Excellence.
- Pears, A. (2010). *Doing Contextual Theology*. London: Routledge.
- Swinton, J. (2011). Being in the Moment: Developing a Contemplative Approach to Spiritual Care with People who have Dementia. In A. Jewell (Ed.), *Spirituality and Personhood in Dementia* (pp. 175-185). London: Jessica Kingsley.
- Taylor, C. (2007). *A Secular Age*. Cambridge: Belknap.
- Turner, D. (1999). *The darkness of God: Negativity in Christian mysticism*. Cambridge: Cambridge.