The Spirit in the Shadows: A Medical Perspective on Alzheimer's Disease

James Dumerauf

The setting was a conference on dementia at the American Psychiatric Association annual meeting in Chicago. The speaker, Dr. Jacobo Mintzer of the University of South Carolina, had just asked the audience a question: "How many of you think that the spirit is gone from an individual with Alzheimer's disease?" The audience was silent and still, contemplating a question most of us had never been asked or had asked ourselves. A second question followed: "How many believe the spirit remains?"

As I joined colleagues, researchers, and clinicians from around the country in raising my hand, I reflected on another meeting fifteen years earlier at the University of Iowa Hospitals. As a third year medical student, I had just participated in a daylong evaluation of a pleasant, humorous eighty-eight-year-old gentleman. His family had brought this World War I veteran and retired personnel manager to Iowa City because of concerns about increasingly severe memory lapses, and I had signed up to assist with the evaluation and "walk him through" the exhausting evaluation process. He was my grandfather.

At that time there was little to be offered Alzheimer's sufferers but "supportive care" during a progressive and inevitable decline. I sat with him and my mother as the faculty neurologist gently confirmed what we already suspected. My grandfather, undaunted, got the ever-present notebook out of his jacket pocket and, after fumbling for a pencil, wrote the words "Alzheimer's disease" on the first page. He didn't want to forget.

The spirit is indeed seen in people who, like my grandfather, do battle with this disease. One sees it in their struggle for place and meaning even as memory fades. One finds it in the tenderness and dedication with which caregivers bring their energy and creativity to bear in providing for the needs of their loved ones. The spirit is present in the dedication of those researchers who have devoted their lives to finding a cure.

Alzheimer's disease is the most common of a group of illnesses called the dementias, which by definition involve a progressive loss of memory as well as the other intellectual gifts—language, problem-solving, social judgment—we rely on to make our way in the world. It affects 4 million Americans and will closely touch the lives of nearly every one of us in some way. In providing a broad perspective on this disease, I hope to address the realities we all face as more and more of us enter the high-risk years.
Overview

"A man's wealth is his memory; in nothing else is he rich, in nothing else is he poor..."

— Alexander James

At the dawn of the twentieth century, people rarely exceeded the biblical "threescore years and ten." The average life expectancy in the United States was just under fifty years, and it should not surprise us that the work of an obscure German neurologist named Alois Alzheimer received little notice. Most people died before entering the high-risk years for the disease that bears his name.

Advances in medicine and public health have changed all of that. By the end of the twentieth century, life expectancy had shot up from forty-seven to seventy-seven years, and both the blessings and the potential afflictions of arriving at threescore years and ten became manifest on a national scale. For some, surviving to those years meant the cruel irony of losing the point of surviving at all—knowledge of family and friends, personal history, and beliefs. Such individuals were described as "senile," and if a cause were ascribed at all it was, for much of the twentieth century, held to be "just old age" or perhaps more scientifically, but equally erroneously, "hardening of the arteries."

Significant progress in this area began only thirty years ago when it was recognized that the most common cause of dementia is the pathology Alois Alzheimer had described in 1906. The "Alzheimerization" of dementia has done much to transform the attitudes of both the general public and the scientific community. What was thought of as an inevitable part of aging was suddenly seen as a disease that could be researched, treated, and perhaps prevented or cured.

The Numbers

Imagine a group of friends, all around sixty-five years of age, gathered for bridge, study group, or coffee klatch. There are twenty of them, and surveys indicate that as a group they would say they are pretty content with their lot in life, and that the vast majority would rate their health as good. Statistically, one of them has early Alzheimer's disease, almost certainly undiagnosed at this point. By the time they are seventy that number will double, and in another five years will double again. If our entire five bridge tables' worth of senior citizens reach the age of eighty-five, somewhere between 25-50 percent (between five and ten of our original group of twenty) will have Alzheimer's disease. As the baby boomers approach the retirement years by the millions, these are sobering statistics. An estimated 14 million Americans will have the disease by 2047.

Not surprisingly, when senior citizens are surveyed about their worries for the future, loss of intellectual capacity ranks consistently at the top. Now more than ever, people are screening themselves for the first signs of intellectual slippage. What makes this self-surveillance so difficult is that we all experience some degree of memory decline as the years go by. Just as the heart and lungs
function less efficiently with each passing year, so also the brain. To see a quick show of hands, simply survey a coffee-shop group of retirees about trouble remembering names.

This universal but subtle decline in short-term memory and retrieval has long been recognized by neurologists as part of normal aging. Like most such phenomena it has an impressive handle—"benign senescent forgetfulness." The two seniors nearest and dearest to me, my parents, have christened such events their "senior moments." These occasional memory lapses do not, by themselves, presage Alzheimer's disease, though they do arouse anxiety about it. Alzheimer's disease is by definition progressive, and it is to the stages of this progression that we now turn.

The Progression

"And of all God's gifts the best one is language—the power to name and proclaim and identify...." — Thomas Lynch, in The Undertaking

People with Alzheimer's disease come to medical attention in myriad ways. There are some commonalities as well. The evaluation is most often prompted by someone other than the patient, usually an immediate family member. This person typically has an immediate concern for the patient's well being (e.g., Should Dad be driving? Can Aunt Sue continue to live on her own?). Typically the family is able to identify a progression of intellectual decline dating back perhaps six months to two years. Walking in with an often reluctant loved one in tow, they ask The Question—could this be Alzheimer's disease?

The answer requires taking a careful history, which will usually bring to light a progressive loss of memory, language skills, and the ability to solve problems and sort out the daily demands of living. Individuals with early Alzheimer's often do a remarkable job of compensating for the insidious loss of memory, relying on over-learned routines and social skills that tend to be preserved in the early going. Not surprisingly, months or even years have passed since the onset of the disease, appreciated in retrospect, before they come to medical attention. If the history is suggestive of a dementing illness, a relatively brief set of intellectual tasks serves to confirm it. Drawing a clock, recalling three objects at five minutes, naming common and less common objects, writing a sentence—these tasks and others comprise a dementia evaluation. Equally important is a thorough survey of what the person has given up doing in daily life. Do they still handle the bills? Do they still do their own cooking? The history often reflects abilities quietly lost over a period of time.

Alzheimer's disease accounts for 50-60 percent of dementia, but vascular dementia (often the result of multiple infarcts or strokes) accounts for an additional 20 percent, in addition to an unknown number who have a combination of both. Of particular importance is the 5-10 percent of patients with a potentially reversible cause for their dementia, such as hypothyroidism, infection, vitamin B12 deficiency, or alcoholism. I have seen an octogenarian
with "obvious Alzheimer's disease" fully recover when her previously undiagnosed urinary tract infection was treated. The importance of a thorough medical evaluation (which typically includes several routine lab tests and a CAT scan or MRI of the brain) cannot be overstated.

Alzheimer's disease, which is classically divided into three stages, is often not diagnosed until late in the early stage, or even into the middle stage (see Table 3). I find it helpful in working with families around treatment and quality of life issues to discuss the stages of the illness candidly and in detail. This is particularly true now that treatments can slow the progression to the more advanced stages of the illness and, ideally, allow people to maintain a good quality of life in the earlier stages of the illness.

COMMON STAGE-RELATED FEATURES OF ALZHEIMER'S DISEASE

Early

Absentminded, difficulty recalling names/words
Increasing forgetfulness
Difficulty learning new information
Disorientation in unfamiliar surroundings
Minor but uncharacteristic lapses in judgement and behaviour
Reduction in social activities both in and out of the home

Middle

Obvious loss of cognitive skills – marked memory loss
Deterioration in verbal skills, range and content of speech diminishes
Increasing behavioural disturbance characterized by frustration, impatience, restlessness, verbal or physical aggression
Obvious decline in social skills
Emergence of psychotic phenomena – paranoid delusions, hallucinations

Advanced

Speech becomes monosyllabic and later disappears
Fleeting psychotic symptoms – often because of super-imposed delirium
Behavioural and emotional disturbance
Loss of bladder and bowel control
Mobility deteriorates with shuffling gait, involuntary movements

The evolution of psychiatric symptoms in Alzheimer's disease places the greatest burden on caregivers, and arguably causes the greatest suffering for patients. A recent detailed review showed significant agitation present at some point in 81 percent of cases, depressive symptoms in 72 percent, and psychosis (hallucinations, paranoia, or delusional beliefs) in 45 percent. Wandering, a major safety hazard that often prompts referral to a fully supervised care center,
occurs in 43 percent. Memory loss represents only a fraction of the disability caused by this degenerative disease.\textsuperscript{4}

The average survival for an individual with Alzheimer's disease, from onset of symptoms to death, is about eight years, but with a broad range of one to twenty years. People with an extensive family history or earlier onset tend to have a more rapid decline. None of the treatments available prolongs survival. However, treatment can slow progression and allow the person more time in the early stages, when they are more functional and less beset with the psychiatric symptoms noted above. Before reviewing available treatments, we should review what we know about the causes of Alzheimer's disease.

**Of Plaques and Tangles**

"No actor ever forgets a role, so I should have realized something was wrong."  
— Maureen Reagan, referring to her father, Ronald Reagan, and the early days of his battle with Alzheimer's

Alois Alzheimer's unique contribution to our understanding of the disease that bears his name was his correlation of changes in the person with changes in the brain. In 1906, after the death of one of his patients with progressive dementia, he applied a special stain to the brain tissue, and observed the now famous "plaques and tangles" found abundantly in the brain of patients with Alzheimer's disease. Because, properly speaking, a final diagnosis of Alzheimer's disease can be positively made only after examining brain tissue (post-mortem, and rarely done), we speak more precisely of someone having "dementia of the Alzheimer type."

The discovery of these observable abnormalities in the brain firmly established dementia as a disease process. But what causes the plaques and tangles, and what do they really mean? Somewhere in the answers to these questions may lie the key to treating, perhaps even preventing, the disease. Much of what we have learned about plaque formation has been discovered in the last fifteen years.

**The plaques.** Plaques are a type of tombstone in the brain. Their presence represents dead nerve cells, or neurons. Plaques are formed in the brain by way of a mistake in production. The brain contains a protein called APP (amyloid precursors protein) which helps maintain healthy neurons. In Alzheimer's disease APP is cut into segments by an enzyme called beta-secretase that makes a shorter, "sticky" protein called beta-amyloid. The beta-amyloid clumps together to form plaques that are toxic to nerve cells. An inflammatory process occurs around the plaques, and neurons in the immediate vicinity are killed. Once a nerve cell dies, it is gone forever, taking memories and mental abilities with it.

**The tangles.** In the healthy brain, nerve cells are supported by a kind of internal skeleton, which has been depicted as a railroad track running the length of the neuron. The ties of the track are held in place by a protein named tau. In Alzheimer's the tau no longer holds the skeleton in place, and the "railroad ties"
twist and tangle, and the nerve cell dies. What causes the tau protein to lose its grip? One theory is that when amyloid plaques press up against the nerve cell, chemical changes are set off that affect the internal skeleton. Currently, this theory is a subject of intense research.

APO E. "What about that genetic test that was in the news recently?" APO E, a protein we all have in the brain, comes in three types. Just as one can inherit the gene for blue eyes or brown, one inherits the genes for APO E2, E3, or E4. Those with the gene for APO E4 may be at three times the risk for Alzheimer's, and those with two genes for APO E4 may have an eight-fold increase in risk. This likely has to do with increased risk for plaque formation.

Our knowledge of such potential risk raises an interesting ethical question. Should we test people for the gene? Thus far, the general consensus among both clinicians and medical ethicists is no. For one thing the finding is not absolute—some APO E4 carriers never develop Alzheimer's disease. Moreover, some Alzheimer's sufferers do not have the APO E4 gene. Most importantly, at this point we have no way to use the information either to prevent the disease or to improve one's quality of life. This may change as more treatment approaches become available, particularly those directed at plaque formation.

Risk factors. There are no hard and fast rules that determine who is at higher risk to acquire Alzheimer's, but some clear associations have been made. The best documented factor is head injury—one elegant study of 2,000 elderly New Yorkers showed that those who had been knocked unconscious as adults developed Alzheimer's at three times the rate of their contemporaries. Lack of intellectual stimulation also appears to be a factor. A number of studies have shown that those with the least education suffer significantly higher rates of Alzheimer's. Whether this reflects a resiliency present in a brain that has been "exercised" over the course of a lifetime, or relates to other forms of childhood deprivation in those with less schooling is unclear. Advancing age is obviously the most consistent risk factor for developing the disease. Having a positive history of Alzheimer's in an immediate family member does increase the risk to some degree, particularly if the disease afflicted that member before age sixty-five.

Protective measures. There have been a number of tantalizing leads around other possible protective factors. Postmenopausal women using estrogen replacement therapy appear to have a reduced risk of Alzheimer's disease, an observation that would only be one consideration in deciding whether such therapy were appropriate for any given woman. Somewhat less robust evidence indicates that use of aspirin and other non-steroidal anti-inflammatory drugs (NSAIDs) over time may also modify risk. There are other potential drawbacks to the continued use of these medications (gastric ulcers and kidney damage, to name two) and the evidence does not support such use as a routine strategy at this point. Although both ginkgo biloba and vitamin E have been touted as potential protective agents against Alzheimer's, the evidence is insufficient to warrant their use.
Our understanding of genetic influences, risk factors, and protective factors relative to Alzheimer's disease changes almost daily, and those wanting updated information would do well to contact the national information number (1-800-621-0379) of the Alzheimer's Association.

Supportive care. On those occasions that Alzheimer's has grabbed the headlines in the past decade, it has generally been in regard to new medications aimed at slowing or stabilizing the course of the disease, or to the experimental work being done to develop a vaccine. Although such breakthroughs are obviously worthy of such attention, in general, no one is writing features like "Family Finds Creative Ways to Provide for Their Mother at Home," or "Senior Center Develops Innovative Alzheimer Care Program." This strikes me as unfortunate, because social supports are still the most important interventions for the majority of people.

The first step in establishing care is to establish the diagnosis. A competent evaluation is important so that patients and families may know that what they face is probably Alzheimer's disease and not something else. The question of whether the patient should be told is often raised. If they are still at a point in the illness where they have the capacity to understand what is being said, they have an ethical and moral right to know. To the extent possible, the patient should have a meaningful say in decisions regarding care.

The diagnosis is generally not completely unexpected by close family members. Providing time to talk about Alzheimer's disease and to clear up any misconceptions about what the diagnosis means is crucial. Getting people in touch with the nearest branch of the Alzheimer's Association for support and additional educational and community resources is also an important step in helping them to build a network of support.

Safety. This issue comes up early and often in working with Alzheimer's patients and their families. Concerns around motor vehicle driving are virtually universal and carry significant emotional and practical consequences. The strong consensus is that patients who have reached the moderate stage of the disease should not drive, but the issue is less clear-cut for those in the early stages. I generally urge people to consider giving up driving early as there is evidence that even mild dementia impairs driving. If the safety concern is obvious, I have always had strong family support in persuading the patient that it is time to stop.

Likewise, an early assessment of access to medications, power tools, and firearms is appropriate, for an episode of confusion could easily end tragically. In our practice, we have made use of an occupational therapist skilled in doing home safety assessments to clarify how the person does with cooking, bathing, and other daily routines, as well as to identify loose rugs or any other "fall hazards" that are generally risk factors for the elderly.

Families are advised about the hazards of wandering, and supervised walks are recommended. Despite the fact that specialized dementia care centers routinely have a WanderGuard system to protect patients from wandering off, we have all seen evening news reports of missing persons with Alzheimer's disease.
Medical identification bracelets are therefore a reasonable precaution for anyone with dementia. The issue of potential wandering is, along with agitation and incontinence, one of the factors that often moves families toward a skilled care facility in the later stages of the illness.

**Principles of care.** Families typically appreciate some basic guidelines that suggest how best to care for and communicate with someone with progressive dementia. Many of these suggest such common sense steps as keeping requests relatively simple, avoiding multi-step tasks, and avoiding frequent changes in routine.

The biggest shift in basic care philosophy has been around the previously unquestioned role of "reality orientation." This strategy involves continually correcting the patient (e.g., "No, it's not 1987, it's 2000" or "You didn't have breakfast with your brother because he died a long time ago.") While the theory has been that this kind of refocusing enables people to stay connected with the world around them, the fact is that such corrections are often a source of frustration and hostility. If the patient is deriving comfort from the idea that he had breakfast with his brother, it may be more appropriate to say something like, "He's been an important person in your life." One does not lie to the patient, but validation of what or who is important in their memory, now fragmented by Alzheimer's, is generally being accepted as providing a greater sense of comfort and coherence.

Similarly, it was once considered demeaning for an eighty-year-old woman with dementia to cradle and care for a doll. Today we appreciate the role such activity plays in providing a sense of comfort and connection with happier times, and with roles (i.e., that of mother and caregiver) which have been meaningful in her life. We have needed to expand our tolerance for the diverse ways one's spirit shines forth when the brain is failing.

Stimulation-oriented approaches such as recreational therapy (crafts, games, pets) and art therapy (movement, music, drawing) have been consistently shown to enhance well being and decrease agitation. This approach extends to "memory cues" such as memory boxes outside patients' rooms, with familiar photos and keepsakes to help them find their way.

Caregivers, especially family members in the role of caregivers, often pay a high price in terms of their own health, both physical and mental (a matter deserving of an article of its own). For instance, researchers estimate that spouses caring for a husband or wife with Alzheimer's suffer a 30 percent incidence of clinical depression. The health and well-being of the principal caregivers is always a part of a well-formulated treatment plan. It is not for nothing that the best-selling book written for Alzheimer's caregivers is titled, *The 36-Hour Day.*

The resources available to a family with an Alzheimer's patient in the home vary widely among communities, but increasingly the role of day treatment centers (both for appropriate stimulation and socialization, and to give caregivers
respite) is an important feature. Various forms of respite care, home health care, or parish nursing care can play a vital role in supporting people in their home.

Only the rare Alzheimer's patient progresses through all the stages of the disease without requiring a move to a skilled care facility. Often this transition, when it comes, is easier for the patient than for the patient's family, who may be struggling with equal measures of guilt and relief. All too often, before reaching this point, they have exhausted their own physical and emotional resources in providing for their loved one at home. As the number of beds in facilities specifically designed for those with dementia is limited, this eventuality should be planned for in advance by visiting and "interviewing" facilities in the area. (It is often a good idea to get on a waiting list that permits one to pass if the placement is not required when a space becomes available.) The Alzheimer's Association has excellent resource material on what to look for in a skilled care setting.

Legal issues. Inevitably, at some point in the illness, the Alzheimer's patient loses the capacity to make appropriate financial, medical, and legal decisions. These decisions then have to be assumed by someone else. The establishment of durable power of attorney for health and financial decisions will avoid the frustration of having to petition a court for guardianship later in the course of the illness. Early on it is very appropriate to have a frank discussion to determine the patient's wishes regarding "heroic treatments" (e.g., feeding tubes or aggressive treatment for other medical illnesses) later in the course of the disease. The participation of patients in such advanced directives insures them of a direct say in their own destiny and relieves family members of emotionally draining decisions later on.

Of Pills and Potions: The Pharmacology of Alzheimer's Disease

The use of pharmacology to help Alzheimer's victims is hardly new. For decades physicians have been prescribing agents to calm the agitation, improve the depression, and quell the psychotic symptoms that attend this illness. Only with the introduction of Tacrine in 1993 has any medication on the market specifically been designed to treat the cognitive symptoms, the memory and functional loss. The effects of this class of medicine, the cholinesterase inhibitors, are decidedly limited. Their introduction is highly significant, however, as they represent the first slight step toward altering the course of the disease. Tacrine and its more widely used successor Aricept, as well as a number of other medications in development, act by boosting the acetylcholine, one of the brain's principal chemical signalers. Tacrine's potential toxicity for the liver has limited its prescription and restricted its market, but Aricept tends to be much better tolerated.

At best, these medications' effects are limited and temporary. They typically work, when they work at all, for only six to nine months, either maintaining or slightly improving functioning for that time. These modest results should not be understated, however, as six months of relative stability may translate into six
additional months a person is able to live at home. Aside from quality of life considerations, this can represent a huge financial saving to society generally. The irony, of course, is that the cost of these medicines places them out of reach for the many seniors who lack prescription coverage. Some promise is also shown by such agents as vitamin E in doses of 2000 IU per day, but again only in terms of a slight slowing in functional decline.\textsuperscript{17} However, no evidence confirms high doses of vitamin E as a preventive measure, and its use should be supervised by a physician.

None of these treatments has been shown to prolong life or change the disease's ultimate outcome. So far we have made only a dent in slightly delaying the course of decline for individual victims. The next decade, however, may well bring progress. In light of recent discoveries, particularly regarding the process by which beta-amyloid leads to plaques, new horizons are opening to us. Researchers and drug companies, for reasons altruistic and otherwise, have the bit firmly between their teeth as they try to find a way to halt the process of plaque formation, thereby sparing nerve cells and the memories and abilities they carry.

Equally intriguing is the possibility of a vaccine that would target the beta-amyloid protein. It would allow the patient's own immune system to gobble up the sticky beta-amyloid before it becomes a toxic plaque. Elan Pharmaceuticals has been working on a vaccine for a number of years. In a rather inspired experiment, a breed of lab mice prone to plaque formation was injected with an extract of beta-amyloid. The immune response this triggered resulted in a decrease in plaques in treated mice. A small safety study of a trial vaccine for early Alzheimer's patients has been carried out by Elan, and the preliminary results show that it is well-tolerated. How effective it may be, or who should get it and when, remain to be determined.

Whether or not any of these treatments are specifically helpful to a given patient, the active and caring role of the person's physician is of paramount importance. Alzheimer's patients are more susceptible to other medical conditions than non-demented individuals of the same age, and are less able to vocalize physical complaints, making increased medical surveillance essential. The family physician also provides one more supportive presence for families as they deal with an unpredictable set of challenges over the course of the disease. This role follows the dictum of William Osler, the great physician of a century past, who described the physician's role as being, "to cure when we can, to care always."

**The Role of the Church**

"And I, mortal though I am, will rest assured in hope, for you will not abandon my soul."

--- Acts 2:26b-27a (TEV)

As our population has aged generally, so has the church's membership. A substantial percentage of RCA members is over the age of sixty-five. To care for
members of our congregations with dementia is a call we can either embrace or ignore, but there is no question that the call is there. Each congregation is blessed with different gifts and resources, and what we offer congregants with dementia and their families is limited only by our collective creativity and willingness to engage.

For the person with early dementia, church attendance may be one of the things they give up before even being able to articulate a problem, and certainly before a diagnosis is made. The burden and embarrassment of struggling with names that should be familiar can keep people from coming to a place they have called their spiritual home for years. A sensitive contact from a pastor, elder, deacon, or friend in the congregation may give members permission to participate in spite of what is, to them, a social disability. In one instance I recall, church contact actually resulted in getting a congregant a much-needed medical evaluation. The loss of mobility which accompanies loss of a driver's license is obviously another barrier which a caring congregation can help overcome.

Parish nurses, where available, can play an enormous role in monitoring and supporting the physical health of a person with Alzheimer's. They can help organize complicated medication regimens and provide emotional support to caregivers in the home. When individuals are cared for at home, respite for the caregivers can be a tremendous blessing, and is a reasonable outreach service which the congregation may be able to organize and provide. It may also be useful to have a person on the appropriate congregational life committee serve as a liaison with the local Alzheimer's Association chapter, as that organization may be aware of a need in the congregation before it comes to the attention of the church office.

Finally, and most importantly, to join with a person with Alzheimer's disease in the ongoing expressions of our faith, in prayer and ritual, in song and Scripture, can provide a tremendous gift of the spirit even as the light fades. In making regular "house calls" at a dementia care unit in my community, I have more than once observed residents, all in the moderate to severe stage of dementia, gathered around a piano as familiar hymns were being played. As heads nodded and hands tapped to the sounds of "Rock of Ages," there was no doubt that the familiar chords were connecting with something deep, profound, and wonderful. I am convinced that the ability to experience the sacred, mediated at times by no more than the touch of a gentle hand, never leaves.

**Conclusion**

*She lay quietly on the bed, clutching the rosary placed in her hands by her daughter. She had not spoken in months, intelligible speech being the last in a series of losses over the past seven years. First there had been the loss of the antique store she had managed alone after the death of her husband, as it became clear that she could no longer keep the books or cope with the demands of the business. Then there had been the loss of mobility, as those who knew her*
best persuaded her that it was no longer safe for her to drive. In rapid succession there was a series of more losses, patiently and impatiently borne, as her home, her continence, and her recognition of long-familiar faces left her.

Her daughter, too, had mourned the losses in ways seen and unseen. Her mother's ability to share the news, trade memories, and dote on the grandchildren had faded away years earlier. The image of a mother long clung to as a shelter in the storm was replaced by images of inconsolable agitation as that mother's ability to cope with daily routines was lost. Finally, there was the loss of hope that tomorrow would be any better than today or yesterday.

As she leaned over her mother's bed, preparing to kiss her goodnight, she murmured the psalm she had heard her mother pray so often, from the time she was a little girl, "The Lord is my Shepherd, I shall not want. . . ." It was a few moments before she realized that her mother's lips were moving, forming words, unmistakably the same words she was sharing with her mother, the same words that people of faith had been saying for thousands of years. The shadow lifted for a moment, revealing the spirit.

ENDNOTES


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