THEOLOGY, NEWS AND NOTES

Maturity of Body and Soul

FULLER THEOLOGICAL SEMINARY
DECEMBER 1995
Introduction

BY COLLEEN BENSON

Americans are beginning to address the last period of life with the attention it deserves. Planning for the later years becomes more and more imperative, along with studying those life changes, as longevity continues to escalate. Today, one-eighth of the population of the United States is over 65. Once age 65 is reached, men can expect to reach 80 and women can expect to live past 84. And next year the baby boomers will begin to turn 50, dramatically increasing the number of seniors in our country.

In the past, the church has tended to reflect the same age bias as the rest of the country. The church budget devoted to youth ministry is typically several times greater than the dollars devoted to the elderly members of the congregation. And this is also true for many churches that have a high percentage of elderly people. Our responsibility to the Body of Christ includes a special responsibility to the older members (James 1:27). In this issue of Theology, News and Notes, we look at several aspects which affect the quality of life as people grow older.

David Moberg, an evangelical sociologist who has been an advocate for increased concern for the elderly for over 25 years, is a long-time friend of Fuller. Dr. Moberg presents an excellent overview of spirituality and aging.

Harold Koenig's article reports some very interesting research on spirituality as it is being used to cope with stress in the lives of mature people. As a physician, Dr. Koenig has been conducting research and writing in the area of religion and its influence upon the aging.

Harold Schreck's article shifts the focus to anthropology. A professor who supervised a study of a changing community in Northeast Minneapolis, Dr.
Spiritual Maturity and Aging

BY DAVID O. MOBERG

Spirituality" has become an "in" word. After a long period of neglect—or even denial of its reality or relevance—itits popularity is evident on numerous scholarly and professional fronts as well as in mass society.

The "discovery" of spirituality among gerontologists has many roots. Senior citizens are the "most religious" age group by every measured criterion, with but one major exception—church attendance diminishes after the age of 75 or 80. Decade after decade this remains true, so the outmoded argument that elderly people are relics from a different period of history can no longer be used to explain away the phenomenon. To live up to the principle of respecting the interests and rights of the people they serve or study, gerontologists are forced to recognize that almost all older Americans are "religious."

The rising interest in spirituality in the general population also has drawn attention to its relevance. The 1971 White House Conference on Aging included a section on "Spiritual Well-Being" that issued numerous recommendations for action. It led to the formation of the National Interfaith Coalition on Aging which, in turn, sponsored significant meetings and conducted research on what "the religious sector" was doing to enhance spiritual well-being.

Even more significant in the scholarly world has been the mushrooming evidence from research that religion and spirituality are significantly associated with health, well-being, and the quality of life. Occasional papers at meetings of the Gerontological Society of America, the Association for Gerontology in Higher Education, and other professional associations, called attention to the subject. The Journal on Religion and Aging (now the Journal of Religious Gerontology) was established, and the Forum on Religion, Spirituality and Aging became a section of the American Society on Aging. Reports on research about religion and aging are scattered widely in medical, psychological, sociological, and other journals, but only recently have significant summaries and interpretations of their findings been heralded in significant books by Harold G. Koenig, Jeffrey S. Levin, and others. These, along with sections and chapters on religion in textbooks, are catching the attention of professional geriatricians and gerontologists.

Meanwhile, clinicians and human service providers of many kinds have been discovering the importance of the human spirit. For example, the nursing profession developed the diagnostic classification of "spiritual distress," and the Nurses Christian Fellowship demonstrated that spiritual care can be provided even in nonsectarian settings. Social workers were reminded of the significant ways in which religious institutions can strengthen the social service system. Psychotherapists and adult educators discovered the spiritually therapeutic effects of sharing life stories.

These and many other developments have brought the subject of spirituality into the consciousness of professional scholars, researchers, and clinicians.

WHAT IS SPIRITUALITY?
The wide scope of implicit definitions and interpretations of spiritual concepts should raise a huge red warning flag among Christians. Unfortunately, however, all too many of them are trapped in the spirit of their age, so they uncritically accept the relativistic definitions of society in the erroneous assumption that the differences are merely semantic, reflecting only divergent labels for identical phenomena.

It is true that all people are spiritual beings. God "set eternity in their hearts" (Eccles. 3:11), so there is a longing for enduring meaning and purpose for life, a search for something that transcends time, an innate sense that there is a future beyond the grave. The body-mind-spirit characterization of each person may be a faint reflection of the one in whose triune image we all are created.

Even apart from the biblical teachings, there are numerous evidences, mostly qualitative and indirect rather than empirically observable, that human nature is essentially spiritual and that many aspects of this spiritual nature can be investigated scientifically. Try as they will under pressure of antireligious biases, scholars and scientists cannot forever obscure the reality of human spirituality. But, as they analyze it, no uniform definition emerges beyond the conclusion that it does exist, after all.

A similar picture is apparent in religious contexts. There are so many implicit interpretations of the nature of spirituality that dozens of varieties are...
evident. Among them are the religiously based forms of Protestant, Catholic, Orthodox, mystical, and Christocentric Christian spiritualities, as well as Hindu, Islamic, Sufi, Buddhist, Jewish, Hasidic, animistic, and humanistic spirituality, many of which have subcategories, to mention some of the more prominent types. A few are broadly theistic, and still fewer Christocentric. Some are success-oriented and others nature-focused. Some aim to defend life of all kinds; others idealize consumption. Some have a goal of self-oblivion and nothingness, while others are self-oriented, seeking self-fulfillment. Some are earth-bound, others eternity-focused. Among those that in some way recognize the word “Christ” are found a confusing array of theologies.

While all the concepts and categories point toward or reflect the fact of human spirituality, they are not mere equivalents of each other. Their broadly sweeping diversity, as well as the specific details incorporated into each religious and philosophical set of interpretations, obviously belies the popular dictum that the differences among the religions are only different expressions of the same central truth.

Christians merely need the simple exercise of comparing each explicit and implied teaching of any specific movement or cult with biblical teachings to discover whether it is or is not a legitimate expression of scriptural truth. They all fit into two main biblical categories: those that worship the one Triune God, and those that are idolatrous. Most of their diverse spiritual paths lead to different, not the same, destinations—just as not all roads lead to either London or Rome.

All definitions of the human spirit are imperfect reductionistic reflectors of the complex reality they attempt to represent. Somehow the spirit is the very essence of the person, the part that will live on in eternity while the mortal body decays into dust and ashes. Yet spirituality is not separate from the material, emotional, intellectual, and other aspects of human life and behavior—but is intimately connected with them all. At best, it infuses them with significance, meaning, and purpose. Made in the image of God, who is Spirit (John 4:24), even pagans, agnostics, and atheists are spiritual beings, but only the spirit that is genuinely confessed by God confuses that Jesus Christ has come in the flesh (1 John 4:1-6).

Although many worldly people see no distinction between religiousness and spirituality, they are not the same. Ideally, all religious agencies and institutions, beliefs, activities, memberships, and experiences are infused with spiritual meaning and have spiritually significant consequences. Each ought to contribute to the other. Most research related to spirituality examines various aspects of religiousness in the assumption (right or wrong!) that these reflect the spirituality of the people investigated.

Yet we are aware of “carnal Christians” who are so immature in their faith that they live like worldly people of society, sometimes trying to “baptize” sinful activities and attitudes with a few biblical prooftexts or motivational expressions—as if good intent is more important than objective outcomes. Historically, the behavior of nominal Christians, whose religious identity is equivalent to membership in an ethnic group rather than a matter of sincere faith in Jesus Christ, has brought great disgrace upon the church when outsiders have seen them as the true representatives of Christ’s kingdom.

SPIRITUAL NEEDS IN OLD AGE
The later years of life typically are a period of declining efficiency of bodily functions as well as of diminished social and occupational activities. Arthritis and other chronic diseases eventually strike most people. Regular visits to the doctor and the pharmacy become more frequent. Hospitalizations of family members and friends become more numerous. Attending memorial services and funerals consumes much time and often brings emotional stress. Children and grandchildren may live at considerable distances, and sometimes at an emotional distance as well. Circumstances of ill health or of financial limitations may require one to move into a smaller home with the accompanying strain of disposing of many family treasures.

Under such circumstances, questions about the meaning of life and purpose for living, expressed in countless ways, often come to the fore. Is there anything left that makes my life worthwhile? If God is love, why does he allow suffering? Why did he take away my friend (in death) instead of me, when she was so much younger? While answers to these are found in the Bible, they are not always obvious. When pastors, Christian educators, and committed church people fail to deal with them, some older people drift away into sects and cults that promise definitive answers.

This also is a time in which many review the entire span of
their lives, putting the tattered and mysterious pieces together through telling and retelling stories of life events, writing memoirs or a family history for descendants, sharing their experiences in support groups, or, more rarely by writing projects that compile living histories for the archives of a university, church, community library, or state historical society.

The life review is a wholesome release that reconstructs many past events from a new perspective, especially if the eyes of faith are turned back to see how God indeed did make all things work together for good for his children (Rom. 8:28). Helping senior adults to do this and stimulating them to recognize how they can continue to be of service to others even when they are homebound—or physically impaired—is one of the most significant ministries pastors and church leaders can provide for older members. It is not at all a one-way street of giving, for they in turn will receive huge blessings as a result.

But old age is not only a period of deterioration and disengagement from earlier social connections. For most "saints of God," it is a time of rejoicing for what the Lord has done, is doing, and yet will do through all eternity. Even in the midst of great difficulties, there is praise for God's goodness, like the raising of an Ebenezer monument glorying in the fact that "Hitherto hath the Lord helped us" (1 Sam. 7:12) and the obvious assurance that henceforth he will do the same.

SPIRITUAL GROWTH WHILE AGING

Usually we think of growth as development and aging as decline. Yet even while the rest of life seems crumbling and everything else appears to be "going down hill" during the later years, there can be continued spiritual growth. Of course, growth occurs only in living organisms. Nowhere is that more true than in matters related to the human spirit.

Spiritual growth is not the same as either spiritual health or spiritual maturity. Those who still are "dead in trespasses and sins" (Eph. 2:1) need to come alive, transformed by a new birth that makes them children of God by his grace. Only then can they begin to grow toward spiritual maturity.

Just as a newborn baby in excellent health, although it is far from mature, so old people who are young in their Christian faith can be spiritually healthful, yet very immature. When others judge their weaknesses and flaws on the same scale of evaluation as

**Spirituality is not separate from the material, emotional, intellectual, and other aspects of human life and behavior.**

are the warnings in Scripture against that kind of pride and self-righteousness (Luke 18:9-14; 1 Cor. 10:12).

My own research has found that persons who are looked upon by other Christians as the most mature or most spiritual children of God are themselves aware of their own imperfections. They compare themselves with Jesus Christ, the exemplar of human perfection, and realize that alongside his integrity and flawlessness, they fall far short of "the whole measure of the fullness of Christ" (Eph. 4:13, NIV). Like the Apostle Paul, they realize that they have not yet attained perfection (1 John 1:8). Although they are indeed saints, biblically speaking, they continue to press on toward the prize to which they have been called (Phil. 3:12-15). They know that they will be fully "clothed with Christ's perfection" only when they leave their mortal bodies, but meanwhile they continue to grow toward the goal of imitating Christ, becoming more and more like him.

Spiritual growth can occur as a result of nearly every experience of life, whether each is viewed as a bane or a blessing. No single formula can be simply given as a prescription for every human spirit, but there are numerous "paths toward maturity" or "means of grace" that

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Faith and Spirituality as a Means of Coping

BY HAROLD G. KOENIG

Persons with health problems frequently use their religion as a way to help them cope with the distress caused by physical illness and disability. Over the past 15 years, a substantial body of scientific research has examined the relationship between religiosity and health outcomes in later life. This research has pointed to a particular dimension of religiosity that has recurrently been associated with better health outcomes, both cross-sectionally and longitudinally. That dimension is religious coping—defined as the use of religious beliefs or behaviors to alleviate the emotional distress associated with psychosocial stress and facilitate problem solving. When community-dwelling or medically ill older persons are asked what enables them to cope with stress or health problems, between one-quarter and one-third spontaneously offer responses with overt religious content. Religious coping increases as persons become increasingly ill or near death. Older persons who use religion in this manner experience lower rates of depression, have higher self-esteem, and also appear to live longer.

Over the past eight years at Duke University Medical Center, we have been involved in the assessment of religious coping among adults hospitalized with medical illness. In my earlier years as a family physician, I frequently noticed patients praying, reading their Bible, or saying the rosary, when I checked on them during my morning rounds. I was curious about these behaviors, and began asking patients why they were doing this. Over and over again, this question prompted an outpouring by the patient of how important religion was to him or her. We would receive a detailed description of how much it helped them cope and how much it provided comfort. In reviewing the medical literature on the topic, I found little useful information. One of the few reports published at that time was an article written by Nina Covault in 1960. Drawing on her experience as a geriatric medicine specialist in her private medical practice, she reported that she had not observed elderly persons asking for more spiritual help when they were ill. In fact, she wrote that during her 25 years of medical practice, no patient had chosen to discuss religious beliefs or spiritual problems with her, or had asked to speak with a minister. Furthermore, she believed that a sick patient who brought a Bible with them to the hospital, and displayed it prominently on the nightstand, was likely to be an insecure individual and a sign of trouble for the physician.

The only published material in the medical literature that spoke in opposition to religion's pathological influences was the work of sociologist David O. Moberg. In contrast to what had been written previously, he reported studies which demonstrated a link between religious beliefs or activities and well-being in later life. What Dr. Moberg reported was exactly what my patients were describing to me and precisely what I had observed in my clinical practice. It was soon afterwards that we began our own research on the topic. At the Veterans Administration Hospital in Durham, North Carolina, we developed a brief religious coping measure that was included in a large epidemiological mental health survey of depression in medically ill patients. In this manner, religious coping (along with other sociodemographic and health variables) was systematically assessed in 1011 consecutively admitted men under the age of 40 (12 percent) and over the age of 65 (88 percent), who were interviewed on the medicine and neurology inpatient services.

RELIGIOUS COPING INDEX

The Religious Coping Index (RCI) is a brief three-item measure that assesses both qualitatively and quantitatively the extent to which religion is utilized by the patient to cope with physical illness and other stressors in life. Administered by an interviewer, we found patients often enjoy responding to the questions.

First, patients are asked in an open-ended fashion what enables them to cope. Whatever the patient gives as a response is recorded verbatim. A response that has a religious content receives a score of 10, whereas one without religious content receives a 0. Second, the patient is asked to rate on a visual analogue scale from 0 to 10 to what extent he or she uses religion to cope with distress.

Finally, the interviewer engages the patient in a discussion by asking how religion helps him or her to cope and then by asking for a specific example.
illustrating how religion was used. Responses are again recorded verbatim. Based on these responses, the interviewer rates the patient on a scale of 0 to 10, based on the interviewer's judgment on how much the patient uses religion as a coping behavior. Inter-rater reliability for the RCI is high (.81).

DURHAM MENTAL HEALTH SURVEY
In the Durham VA study, the RCI was correlated with numerous physical and mental health outcomes—both cross-sectionally and longitudinally. Religious coping was positively related to medical illness severity, but was inversely related to both self-rated and observer-rated depressive symptoms—particularly in men who were physically disabled. Furthermore, RCI scores independently and significantly predicted improved mental health outcomes when individuals were reassessed over time. It did not, however, predict mortality.

Religious coping is not a static variable that remains constant with little variation over time. We found that a person’s use of religion as a coping behavior is complex and dynamic, frequently changing in response to stressful circumstances. When we asked patients a series of questions related to their use of religion as a coping behavior, we hoped that the answers to these questions might help clarify why these patients used their religion in this manner. The questions included the following:

- How many years have you used religion in coping?
- How does religion help you to cope?
- Have you ever experienced a distinct change in your feelings about religion that resulted in either a strengthening or a weakening of your religious faith?
- If yes, how old were you then?
- Can you describe what that was like? (positive or negative change, circumstances)
- As you have grown older, has religion become more important, less important, or stayed the same?
- Were your parents religious people?
- Who was more religious, your mother or your father? (other caregiver?)

Ten percent of the overall sample reported they had found religion helpful only within the past 5 years, especially men among under the age of 40. Nearly half of the patients reported that religion had been used to cope throughout life (35 percent of young men, 52 percent of older men). Interestingly, religious coping was strongest in men reporting its use over the past 10 to 25 years only and lowest among those finding religion helpful only within the past 5 years.

Thirty-six percent of the men indicated that they had experienced a significant change in their feelings about religion at some point in their lives. Most (84 percent) reported experiences that increased their religious faith. Younger men were more likely than older men to have reported a distinct change in their feelings about religion (54 percent vs 33 percent). The median age when faith changed in younger men was 26 years, whereas it was 40 to 45 years for older men. Among men over age 65, 42 percent indicated that such a change in faith had occurred after the age of 50.

Religious coping was strongest in men who reported experiencing a distinct change in their feelings about religion, compared with those who had no such experiences. Thus, men who had a distinct religious experience at sometime during their lives were much more likely to use religion as a coping behavior when they were hospitalized with medical illness.

What changes in the importance of religion correlate with age? The majority (60 percent) of respondents reported that religion had increased in importance as they had grown older, whereas 35 percent indicated that it had stayed the same and only 5 percent reported a decrease. The age of the respondent interestingly had little effect on these proportions. Religious coping measured by the RCI was highest among men who reported an increase in importance of religion with age, suggesting that religion’s importance in their lives was increasing—especially for those men who used religion as a coping behavior. Furthermore, depressive symptoms measured by the Geriatric Depression Scale and Hamilton Depression Rating Scale were significantly lower among those reporting an increase in religion’s importance with aging, compared with those indicating a decrease.

To what extent did the religion of these men’s parents affect their level of religious coping while now in the hospital? Patients who reported that religion was important to both parents (38 percent) also scored highest on religious coping, whereas those who reported neither parent as being religious scored the lowest. Interestingly, among younger men, those who reported only their father being
religious or neither parent being religious scored lowest on religious coping. On the other hand, in older men, religiosity of their father was the most important predictor of current religious coping behavior.

PROFILE OF THE RELIGIOUS COPER

Using scores on the RCI, we developed a “profile” for patients most likely to use religion as a coping behavior. Education, income, employment, occupational status, family history of psychiatric problems, and specific medical diagnosis were unrelated to the degree of religious coping. On the other hand, those most likely to use religion as a coping behavior included the following types:
- older men
- married men
- those living alone
- those with high social support
- those severely ill or more disabled
- those with better cognitive functioning
- those with a history of psychiatric problems
- African-Americans
- abstainers from alcohol

CHANGES IN RELIGIOUS COPING

Finally, we examined changes in religious coping as they occurred over time in patients readmitted to the hospital. While there was virtually no change in average religious coping, individual patients experienced significant changes. One-quarter of the sample increased by at least five points and one-quarter of the sample decreased by at least five points. Younger men tended to increase in their religious coping over time more than did older men.

Regression modeling was used to examine changes in religious coping over time. After controlling for baseline religious coping, several variables remained as significant predictors. Interestingly, as the time interval between admission and follow-up increased, religious coping also increased. Many of these patients had progressive physical illness and worsening disability. This suggested that a change in physical health may have affected religious coping behaviors. Likewise, as functional status improved, patients tended to decrease in religious coping. Finally, men with high social support were more likely to demonstrate an increase in religious coping over time.

AVENUES FOR FUTURE RESEARCH

Virtually all of the clinical studies done thus far have measured religious coping with only one or two broad general questions about whether or not religion is a source of comfort. Despite increasing evidence showing a relationship between religious coping and a variety of positive health outcomes, we know very little about the specific aspects of religion’s use that are responsible for these therapeutic effects—or, on the other hand, which aspects are responsible for promoting negative health effects, thus canceling out other more salutary effects. Only recently have investigators examined in detail the ways in which persons use religion to cope, and the effects that different types of religious coping have on health outcomes. Using a conceptual framework based on the work of Richard Lazarus and his colleagues, Pargament and his coworkers have examined specific types or forms of religious coping and related these to both positive and negative mental health outcomes.

Furthermore, religious coping methods appear to predict the outcomes of negative life events more strongly than general measures of religious belief, practice, and salience. While religious forms of coping are related to nonreligious coping methods, the two forms of coping are not redundant. Both add unique variance to the prediction of adjustment to major life crises. Though this work has largely been done in younger adult, relatively healthy populations, those who are less likely than their elderly counterparts to use religion as a coping behavior.

The time has come for a combined effort that utilizes the extensive theoretical and measurement advances developed in younger populations and applies them to older adults with acute and chronic physical health —Please turn to page 22.

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The Church as Community Builder

BY HARLEY SCHRECK

Many people live all their lives in cities. Some are lifelong residents of a specific neighborhood. They are born, interact with, and learn from their surrounding social worlds as children; then develop and grow into adulthood, marry and beget children; see these children leave and establish their own families; and grow old in these same neighborhoods.

Older persons who have been lifelong residents in urban neighborhoods live in the present while referring to understandings and patterns of interaction learned throughout their lives. These past and present realities combine to shape how they understand the world in which they live, interact with others, and carry on their daily lives.

The church should not be the source of persons who play key roles in the social support networks of older persons. The church can be the healing community for older persons. It is here that the local church often becomes highly important for older persons. Churches become advocates for the elderly and design programs of service that are effective in mediating the effects of life in cities. Churches can also be the source of persons who volunteer services to older persons in need. It is into this area that the local church should step to form a healing community for the older person. The church can be the source of persons who play key roles in the social support networks of older persons.

RESEARCH METHODS

In 1994 and 1995, I carried out ethnographic research in Northeast Minneapolis focused on the situation for older persons who were lifelong residents of the area and the contributions of local churches to their abilities to cope with change and the challenges they faced. My key activities were conducting life-history interviews with long-term residents and sending surveys to local churches, followed by group discussions with community pastors. Elderly persons were selected for the research to provide a stratified representative sample, based on ethnicity and area of the city. Twenty-one persons were interviewed, with a focus on their life experiences, patterns of receiving and giving help during crises, and the role the local church played in their lives.

NORTHEAST MINNEAPOLIS

Northeast Minneapolis was settled in the late 1800s and early 1900s by French Canadians, Germans, Swedes, Norwegians, Poles, Russians, Ruthenians, and Italians. As these immigrants arrived, they settled close to persons similar to themselves and began to establish the shape of the community. They moved into neighborhoods around churches that reflected their ethnicity and spoke their languages. Churches were vital to them as they helped build a sense of identity, constituted a source of help, and offered a means toward incorporation into American life. In some neighborhoods, ethnic communities were formed—such as the Russians who settled in the western part of Northeast Minneapolis—which were geographically well-defined, relatively homogenous, and centered around the local church. Other ethnic groups, such as the Lithuanians, were less well-defined geographically. Still others—such as the Germans and Swedes—who could more easily conform to the majority Anglo culture, quickly adopted a new American identification. Yet, in general, the neighborhoods in which they lived made up the most part of their social and cultural worlds. And churches were central to these worlds.
Phyllis' Story

A lifetime spent in one neighborhood is best understood through individual stories. In this case, the story takes the form of the life history of “Phyllis”.

Eighty-three years is a long time. Yet for Phyllis it seems like only a blink of an eye. Seventy of those years were spent in one house, an easy walk from the church, grocery store, and school. Phyllis moved to Northeast Minneapolis when she was almost two years old. She was a member of the Cradle Roll at the church that she still attends. Swedish was the language of her church. She understood some of it. After church, her father, mother, two sisters, and three brothers would gather for dinner. Phyllis also enjoyed playing with her cousins. Phyllis remembers school as great fun but “strict.” Edison High is still standing. The building looks the same but the students are very different. They wander around a lot. She wonders if they ever go to class.

After Edison, Phyllis wanted to become a nurse. But her father told her that this would be unfair to the family. Phyllis’ mother needed help with such a big house, and more income was needed during the 1930s depression. Besides, the boys still had to finish high school. So she found a job in downtown Minneapolis. Her secretarial courses at Edison came in handy. She worked there for 14 years. Phyllis never married. She helped her mother with the house and was active in the Baptist Young Peoples Union (BYPU). As she grew older, she quit the youth group and joined the same women’s missionary circle as her mother.

In 1944, Phyllis wanted a change. So she went to California with a girlfriend. There were jobs out there and not enough workers. Although she loved it, after about a month she was called home. She remembers her father’s phone call. Her brothers were gone. The housework was too much for her mother. Her dad had to slow down, so there was less money. She had to come home. She had responsibilities.

Phyllis came back to Minneapolis and was rehired at her old job. She continued to attend the church. But the church had changed. English was now used in all the services. She found it hard to fit in. The Sunday school class for her age group was called “Homebuilders” and was for people with families. But she loved her mission circle. In 1952, however, the pastor decided that the church was too old fashioned and that the mission circles needed to be replaced with women’s groups. Phyllis’ mission circle was split up and its members distributed throughout the new groups—which lasted less than a year. Later, new groups were formed, but they too disbanded. It was a lonely time.

In the 1960s Phyllis’ mother and father died. She was left in the family home with two other sisters. She decided she had worked long and hard enough. She quit her job and stayed home to take care of the house. She and her sisters continued with their church life and their lives together. That was a good and quiet time.

In 1983 Phyllis’ oldest sister announced that the neighborhood was going downhill, so she thought it was time to sell the house. Besides, it was getting too much for them to maintain. The sisters sold their home, split up the furniture, and moved into three separate apartments in a new senior high-rise just a few blocks from where they had lived. They continued to attend church, but now there was a church van that picked them up. It was easier to find friends at church now, as many of the women were losing their husbands and seemed to have more time.

Six months after they moved into the high-rise, Phyllis’ older sister suddenly died. Soon afterwards, her younger sister became sick. Phyllis described her life then as living on the staircase, running up and down between her apartment and her sister’s. After months of illness, her sister died.

Phyllis packed up her sisters’ apartments and sorted through their belongings, making sure that her brothers, nieces, and nephews received the family treasures that they wanted. Then she settled into her new life alone. Her brothers were married, had families, and were ready to retire. They lived in other parts of the city. She saw them a couple of times a month and spent holidays with their families.

She continued going to church and made some new friends in the high-rise. For awhile, she was secretary to the resident’s association. Then the city expanded the residence and the proportion of older people decreased. New strange people moved in. The meetings became stressful, and the older people didn’t get to speak much anymore. She stopped going to the meetings. She also stopped using the stairs. She wasn’t sure who would be there—or what would happen.

In fact, “Northeast” was changing. She used to do most of her shopping on Central Avenue. Now she didn’t shop there much. There were new types of people there—people from other countries. They made her uncomfortable.

Today, Phyllis continues to live in her apartment. The walls are covered with pictures of her father, mother, sisters, and brothers—taken when they were young. Pictures of her brothers’ families sit on end tables. She is proud of her nieces and nephews who are doing so well.

Phyllis still goes to church. She never misses a Sunday or a social. Wednesday night services are a little harder to get to. Her friends don’t get out much now. In fact, her friends are often sick—and some have died.

One particular friend is bed-bound after falling and breaking a hip while she was out with Phyllis. Phyllis feels terrible about it and blames herself. She had talked her friend into going out that day. So she spends almost every morning at her friend’s apartment, helping her. It’s the least she can do.

*This pseudonym is used to protect the identity of “Phyllis.”
Phyllis has lived most of her life in Northeast Minneapolis. She was born in a pre-automobile, pre-electricity world and has lived through massive change. She has coped with many crises: the death of loved ones and friends, economic stresses, wars and national emergencies, unfulfilled dreams, and declining health. While she was living through all this, she was enmeshed in a certain context, which made up her "effective community"—that portion of her world that was accessible to her as possible sources of support. In a positive sense, her effective community was crucial to Phyllis' ability to weather crises and transitions. It became the source of instrumental, affective, and, oftentimes, spiritual support. Members of Phyllis' effective community helped her find jobs, bury her parents, and reach decisions about housing options. They offered her shoulders to lean on and listening ears to hear her concerns. Yet there has also been a negative side. At times, members of her effective community have limited her and presented demands that were difficult and demanding. But, negatively or positively, they made up her world and helped determine the quality and direction of her life.

**OLDER PERSONS, URBAN CHANGE, AND THE CHURCH**

Northeast Minneapolis—like other urban communities throughout the nation—is filled with people like Phyllis. As long-term residents in neighborhoods that have undergone massive change, these people were born and raised in strikingly different social, cultural, and technological settings than those in which they now live. They have learned how to cope with challenges brought on by many crises. Part of this coping has entailed providing or receiving support from members of their effective communities. Yet these have also been greatly affected by many societal changes. Both the composition of these communities and the character of helping have changed.

The oldest residents of Northeast Minneapolis spent their childhoods and youth between two world wars. This was a time when roads were being paved, electricity was being installed, and the residents lived in small, well-boundaried neighborhoods. Few strangers were seen in these neighborhoods, and many people still spoke their native languages. The core values of hard work, thrift, and community identity were the guiding principles.

World War II was a key event for this generation. Those who went into the armed services experienced profound changes. For those who stayed behind, World War II began a period of relative prosperity and opportunity. After the war, the people of Northeast Minneapolis went to work. They were busy with their jobs, their families, and life in their neighborhoods and churches. At first, there was postwar economic growth. But by the 1960s, and 1970s, the economy slowed and Northeast began to decline. As retirement came nearer for most Northeast residents, changes began to occur that worried them. Their children were finishing school. Some went on to college. And many moved out of Northeast into more modern homes in the suburbs.

The population in Northeast was changing. The community was still predominantly populated by graying European immigrants and their descendants. There were few people of color. The newer people who moved to Northeast were younger, poorer, and more prone to rent than buy.

Meanwhile, the character of life in the community was changing. The elderly people in Northeast Minneapolis felt that the new people were not as friendly and outgoing as people once were. Loyalty and trust that were characteristic of Northeast were breaking down as the gulf widened between neighbors. Relationships between customers and business owners became more remote and superficial. Businesses now seemed to be owned mostly by persons living outside the community. Life seemed less secure. Rumors of crimes began to circulate.

Today most of the people are elderly and retired. They find this a good time of life and agree that life is much easier than it was for their parents. But the neighborhood continues to change. Familiar schools have closed. Children from Northeast (still a predominantly white community) are going to schools in South and North Minneapolis, which have much larger populations of African-Americans. Children from South and North Minneapolis are going to school in Northeast. The presence of young people from outside the neighborhood is frightening. This is often aggravated by a generalized fear and lack of familiarity with people of color or people from other lands.

Most people feel increasingly insecure. The elderly believe that it is not safe to take walks in the neighborhood and that it is important to keep their doors locked. In the past year, there have been highly publicized murders and rapes in Northeast.
This has terrified the people of the community. Rumors of even more problems circulate. Few have actually been victims of crime, yet all these elderly residents expressed feelings of victimization.

Finally, Northeast Minneapolis, a place where strangers were once rare, is now full of new, unknown people. Those who are walking the streets, moving into neighborhoods, and operating stores look and act differently. Sometimes this is a difference of unfamiliarity. Sometimes it is a difference of lifestyle or behavior. More frequently, it is a difference of skin color or nationality. There are few occasions that encourage interaction between older, long-term residents and the new arrivals. There are many reasons given for this. Today, people stay inside their homes with their air conditioners humming and televisions blaring, instead of sitting on their front porch or in their backyard where they can see and talk to neighbors. When neighbors do go outside, it is to mow the lawn or to dash to their cars and drive off to other parts of the city. Northeast is now a community of strangers.

Church leaders need to build healing communities through expanding the effective communities of those in need.

Churches have long been part of Northeast Minneapolis and have been important in the lives of the elderly citizens. (All but one I interviewed have been lifelong members of a neighborhood church.) Churches helped shape Northeast and build community. Friendships formed at church were more important than one's neighbor and almost as important as kin.

Sometimes churches and their ethnic congregations created tensions in Northeast Minneapolis. Until recently, there was a severe division between Catholics and Protestants that was clearly revealed in warnings against intermarriage. Russian Orthodox children sometimes had to run through a barrage of snowballs from Polish Catholic kids (and vice versa) on the way home from school. Conservative, fundamentalist Protestants looked askance at their liberal brethren, and vice versa.

In the midst of all this, Northeast's long-term residents enjoyed life, faced crises, and became survivors. The people were strong and self-reliant. There was a shame in being too needy. Yet help was given and received. Members of families cared for one another. They helped provide housing when needed, they tended the sick, they helped each other find jobs, and they brought food in times of crisis. Relatives also helped, depending on how close the relationship was, how far away they lived, and their financial status. Churches helped too, but only to a certain extent. The people firmly believed that churches were places where spiritual guidance was expected. Churches were good for marrying and burying. But to go to the church to seek financial help was thought shameful. It just wasn't done.

Today, crises still come and Northeast's elderly residents continue to give and receive help. Family members still provide support when needed, but there are less of them now. Children have moved away. Families have fewer children. And there are cultural expectations of independence. Also, because many families today occupy the minimum amount of living space, it reduces the possibility of the elderly moving in with their adult children. Besides, members of the new generation are busy with their own careers and families. The government helps out the elderly now, but there is hesitancy among many older people about accepting this type of help. The church is still there, but pastors report a continued sense of self-reliance among elderly people that makes it difficult to help those who have needs.

The Church's Role in Times of Change

As many other metropolitan communities, Northeast Minneapolis has clearly gone through much change. These changes isolate the elderly from the new arrivals. The old ways of building communities and neighborhoods have broken down. There is an increasing gulf between the old and the young, between whites and persons of color, and between persons of different socioeconomic classes.

There is a vital need to reknit the fabric of community in America's cities. The local church is vital to this effort. Historically, churches have helped define—Please turn to page 22.

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'And Abraham Laughed':
A Theology of Aging and Impairment

BY CORDULA DICK-MUEHLKE

Life in the midst of death: this is the promise and paradox that God offers us. The Scriptures are replete with demonstrations of this promise. Christ’s resurrection, the penultimate example of this promise, is foreshadowed in the raising of Lazarus, Jairus’ daughter, and the widow’s son from the dead. A similarly astounding event occurred when God brought forth a life, the baby Isaac, from an aging, "barren" woman, Sarah. The surprising birth of Isaac to Abraham and Sarah, who laughed at the possibility of having a baby, beautifully illustrates God’s promise of life in the midst of death. As far as childbirth was concerned, this couple presumed themselves "dead." In their laughter, Abraham and Sarah revealed skepticism about God's ability to overcome the limitations of aging. Through the birth of Isaac, this elderly couple’s assumptions about God’s and their own capabilities were overturned.

The story of Abraham and Sarah provides the basis for a theology of aging and impairment which recognizes that God can break through the limitations of aging. Older adults, especially those who are impaired, are constrained by societal stereotypes which cast them as "barren," that is, as needing care but having nothing to offer. God’s promise of life in the midst of death is typically forgotten by those who live with or care for impaired older adults.

An outgrowth of my work with caregiving families for the past 10 years, the theology of aging and impairment presented here is directed specifically at older adults afflicted with Alzheimer’s disease (AD) or a related disorder. As the number of persons with AD in the United States increases from the present 4.1 million to a projected 14 million by the middle of the twenty-first century, a theology of aging and impairment will be needed to combat the devaluation of these older adults. Over a period ranging from 5 to 25 years, the person with AD experiences progressive cognitive decline, personality changes, behavioral problems, and impairments in basic activities of daily living such as eating and dressing. As memory and other cognitive abilities are lost, the afflicted individual becomes increasingly dependent on a caregiver and can no longer be left unsupervised. Eventually, the person will fail to recognize even close family members and may become mute or enter a vegetative state. This article addresses the profound yet often unrecognized spiritual crisis which persons with dementia face.

This crisis is rooted in dehumanizing societal attitudes toward cognitively impaired older adults. Severe cognitive, emotional, and personality changes often lead caregivers and others to assume that the person with dementia has ceased to exist in any meaningful way. Consequently, interest in cognitively impaired older adults is focused not on their past and current experience as persons but on their value as patients to be studied. In response to a societal fear of the aging process, researchers driven to find a cure for AD frequently turn the afflicted into objects. The ongoing emotional and spiritual needs of cognitively impaired older adults are likely to be overlooked when curing a disease like Alzheimer’s takes precedence over caring for the afflicted.

Two conceptualizations of spirituality and aging provide a framework for understanding the unique spiritual crisis of the person with AD. At the onset of this discussion, it should be emphasized that spirituality involves a profound search for meaning through self-transcendence and, according to Pamela Reed, may or may not include formal religious participation. Many theologians, such as William Meissner and Robert Richter, have drawn on the work of Erik Erikson, a developmental psychologist, to understand the spiritual challenges of older adulthood. According to Erikson, the life cycle is comprised of eight interrelated stages. During each stage, a conflict between healthy and maladaptive forms of interpersonal adjustment create a psychosocial crisis which the individual must resolve. For example, in infancy, the psychosocial crisis involves a conflict between trust and mistrust. If the infant can count on the mother...
predictably feeding him or her, trust in others is learned and the psychosocial strength of hope emerges. Healthy development involves successfully negotiating and balancing similar polarities in the succeeding stages so that the positive disposition predominates. Finally, the aging individual must resolve the psychosocial crisis of “integrity versus despair.” In this last stage, a lifetime of unresolved issues and concerns confront the older adult, who can choose to view the past with integrity or with despair. Reconsidering and reevaluating the past through life review, the older adult either comes to affirm and accept life as it has been and is—or becomes stuck in regret over earlier actions and decisions. Those older adults who are able to “endorse” rather than reject the past achieve ego integrity and develop the psychosocial strength of wisdom.

Meissner proposed that each of Erikson’s developmental stages involves a psychospiritual as well as a psychosocial crisis. While negotiating the final psychosocial crisis of integrity versus despair, the older adult confronts the fundamental issue of ultimate meaning at the psychospiritual level. According to Meissner, the irreligious person can find ultimate meaning through Erikson’s form of wisdom, that is, the ability to maintain “a kind of informed and detached concern with life itself in the face of death itself.” In comparison, the religious person has the opportunity to achieve a more profound form of wisdom, informed by the resources of revelation and faith.

Faith-based wisdom presents itself as an understanding that life’s meaning is rooted in a spiritual order directed by a loving God. This wisdom emerges through a life review process which includes confession, repentance, and forgiveness. Richter described confession and repentance as approximate religious counterparts to the psychological dynamic of reinterpretting or “reframing” past experiences in light of new insights. In Shepherds and Bathrobes, T. Long suggests that repentance can be understood as a “revising of the past,” which involves facing, embracing, and letting go of the pain that one has inflicted on oneself, others, and God. Repentance requires accepting responsibility for how one’s life has been lived and leads to the experience of forgiveness, or a sense of release from the hurt and anger of the past. Engaging in this process enables the older adult to discover the presence of God in new ways and develop faith-based wisdom. At the culmination of spiritual development, charity, or the giving of oneself in service to others.

**Spiritual growth involves self-transcendence, a search for meaning, and the giving of oneself in service to others.**

Beginning with this refusal to disengage from life, spiritual growth in the elderly involves facing the issue of death—in its final form and as it is foreshadowed in the multiple losses associated with aging. “Little deaths” in one’s personal world serve as rehearsals for the final departure from life, and confront the older adult with the basic paradox of being human, that is, the battle between eros (life forces) and xanatos (forces of dissolution). Spiritual growth occurs, according to Bianchi, when an older adult does not try to escape or otherwise defend against this paradox, but instead searches for meaning in the inevitable conflict between the desire to pursue life (eros) and the limitations of aging and death (xanatos).

A personality transformation, which John LaFarge described as “growth through diminishment,” takes place as the older adult embraces and transcends the limitations of aging and death. The concept of growth through diminishment is reminiscent of Paul’s assertion that God’s power is made perfect in weakness (1 Cor. 12:9). To embrace one’s diminishments as a source of spiritual growth requires faith and hope. Bianchi asserted, “One has faith that beneath, through, and beyond the diminishments there is a life-giving power that will draw special good for humanity and the world of nature from the diminishments.” The diminishments, then, act as a purifying catalyst for a personality transformation in which internal growth is expressed outwardly through greater social involvement.

Whether viewed from the perspective of Meissner and Richter, or Bianchi, spiritual growth involves self-transcendence, a search for meaning, and the giving of oneself in service to others. To experience spiritual growth as described by these
theologians, older adults must have the cognitive resources to engage in processes such as life review, repentance, and a search for meaning. Is spiritual growth, then, unavailable to older adults who lack the requisite cognitive abilities for these processes? What, if any, spiritual experiences are accessible to older adults who, due to AD or a related disorder, can no longer talk about the past in a coherent manner or reevaluate earlier actions and decisions?

To answer these questions, one must understand the unique spiritual dilemma of persons with dementia. Their spiritual crisis can be summarized in one word: disconnectedness. The person with dementia gradually becomes disconnected from self, others, and God by the underlying disease process and by others’ often negative reactions to the cognitive decline. As dementia strips away recent and, finally, long-term memories, the afflicted person becomes disconnected from self—from a lifelong identity of who one has been. Disconnection from others occurs as the afflicted loses language abilities and eventually fails to recognize even familiar persons such as a spouse or a child. The afflicted one is further isolated when friends and family members find it difficult to cope with cognitive impairments, personality changes, or behavioral problems stop visiting. At an intrapsychic level, the impaired older adult loses the capacity to remain connected to others in their absence.

The clinging behavior, fear of abandonment, and desire to “go home” commonly exhibited by persons with dementia are indicators that cognitive impairment can interfere with the capacity to maintain internal, comforting images of significant others. Western culture—which values productivity over personhood—compounds this isolation by marginalizing anyone outside the work force. In a society in which the only worthwhile contribution one can make is a tangible product, persons with dementia become valueless. Finally, cognitively impaired older adults also become disconnected from God. Although God is continually present, dementia disrupts the ability to draw on religious resources for coping.

Given the devastating cognitive and intrapsychic changes associated with dementia, it might be concluded that the afflicted cannot experience spirituality or benefit from ministry. Spirituality, however, is an emotional as well as a cognitive process, and can involve nonverbal as well as verbal channels of communication. As even severely demented persons are emotionally sensitive and can continue to express themselves nonverbally, efforts to facilitate spirituality in these individuals ought to be continued, even after cognitive and verbal abilities decline dramatically.

Can the demented experience spiritual growth, described earlier as an increased awareness of life’s meaning in relationship to a benevolent God, without cognitive understanding? If so, how can those who minister to the demented facilitate this experience of meaning or connection to God at an emotional level?

Spiritual growth in persons with dementia is made possible through an approach to ministry which, according to Thomas O’Connor, involves, “a different way of thinking, a different way of relating, and a different use of traditional religious symbols.” O’Connor found ministry to nursing home residents with dementia frustrating until he stopped viewing them as hopelessly in despair. Replacing this negative perception with the assumption that these impaired individuals had already achieved ego integrity enabled O’Connor to hear the wisdom within what appeared to be gibberish and incoherent communication.

My own shift in thinking about persons with dementia has been informed by a belief that all human beings bear the imago dei, that is, the image of God. An extensive debate has taken place over the centuries about the locus of the imago dei, that is, between the Aristotelian notion of the imago as essentially rational and the Augustinian concept of the imago as primarily relational. If reason or intellect is central to the imago dei, as the conservative evangelical theologian Carl F.H. Henry suggested, it might dangerously be concluded that persons with dementia at some point lose that special quality of life which differentiates humans from nonhumans. If, however, the imago is primarily relational in nature, as theologians within the Reformed tradition such as Emil Brunner, Karl Barth, and G.C. Berkouwer have proposed (as reviewed by Ray Anderson), persons with dementia must be viewed as retaining their personhood throughout the cognitive decline. Those who, like myself, hold the latter view can readily recognize the imago within even severely demented persons.

Repeatedly, cognitively impaired older adults who
appear incapable of relationships have surprised me with their capacity to connect with others and with God. My interaction with a severely demented adult day-care participant over ten years ago stands out as an example: At a moment when trying to make sense out of this man’s garbled, rambling speech seemed futile, he stopped his pacing, turned to me and stated clearly, “Trust in the Lord. . . . Lean not on your own understanding.” A few days later I learned that he had died. While some might explain this man’s behavior as simply the rote repetition of well-learned material, for me it remains a testimony to the reality that wisdom can emerge through the cracks of dementia. Like Abraham, I could laugh no more in skepticism. In the midst of this man’s dying had come the surprise of life—of connection to me and God.

More recently, I had to send a note home with a severely demented adult day-care participant. I approached him at noontime, asking to pin an envelope to his shirt pocket, in order to prevent it from being lost. As I accomplished this task, I apologized that he’d be “wearing” the envelope all afternoon, and explained that I wasn’t waiting until later to give him the note out of a fear of forgetting to send it with him. This man, who typically speaks in garbled phrases, clearly proclaimed, “You’re a little like me then,” and we both laughed. In a moment of connection—of relationship—between us, this severely demented man shattered any illusion that being cognitively intact gave me an edge over him. Relationship is possible even when a person with dementia becomes mute.

My current relationship with a mute adult day-care participant is based on eye contact and touch. When I stop to say hello to her, she typically responds by looking me in the eye, smiling, and sometimes touching my face before she continues pacing. And finally, when it appears that all relational capacities have diminished, I wonder whether the imago ends or is just dormant for some time in the transition between life, death, and resurrection.

O’Connor also changed his way of relating to demented nursing home residents. He gave up the expectation that the residents would recognize him from visit to visit and stopped

We can become vehicles for God’s love to persons with dementia by valuing them, listening to them, and affirming them.

using many traditional forms of ministry, such as prayers and sermonettes. To benefit from these forms of ministry, one must have the capacity to take another’s perspective and track a complex message. Since persons with dementia lose these abilities, prayer, for example, may produce minimal or negative responses. A distractible, confused older adult may wander away during a prayer and, as a result, the pastor or other visitor may become frustrated and return less often. The troublesome behavior of wandering does not indicate an absence of spiritual needs, but simply that the pastor chose the wrong approach to helping the demented person connect with God. Recognizing that certain traditional approaches to ministry have limited usefulness with the cognitively impaired, O’Connor shifted his focus to the here-and-now. Understanding the world of each person became more important to O’Connor than reality orientation. Rather than correcting reality distortions, O’Connor began validating and affirming the residents and their perception of reality. Through careful listening in a relationship that emphasizes presence, the pastor or other visitor becomes a witness to God’s love.

Finally, O’Connor started using religious symbols in nontraditional ways. After residents repeatedly avoided answering O’Connor’s questions about God, he shifted from a verbal to nonverbal way of relating. Traditional symbols that residents could see, hear, touch, or smell (such as taped hymns, a stuffed lamb, or spiritual cards with Bible scenes) provided O’Connor with an avenue for reaching the residents on a spiritual level. For example, when O’Connor showed the stuffed lamb to one severely impaired resident, she took it and recalled an incident in which her father found her after she’d gotten lost. O’Connor interpreted, “You were scared—like the lost sheep. Your father was a good shepherd and he took good care of you. You trusted him.” In addition to symbols, rituals such as taking communion, singing favorite hymns, or

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Faith Development in the Elderly

BY COLLEEN BENSON

This article explores the process which produces the positive attributes we tend to associate with spiritual and/or emotional maturity, such as integrity, faith, wisdom, hope, and a sense of purpose. The Eriksonian model of development is used as a framework to increase our understanding of these qualities as they develop across the life span. While the earlier stages are briefly summarized, the main focus will be on midlife and later life.

ERIKSON'S LIFE-CYCLE MODEL

In psychologist Erik Erikson's last book, before his death in 1994 at the age of 92, he reported and analyzed interviews with 29 octogenarians who had been part of a longitudinal study since 1928. The authors of the study interviewed each person more than once and developed conclusions based on the eight stages of psychosocial development. The focus of the study was the remaining potential of the last interactions of life and the vital involvement in the disengagement of later life.

Erikson presents eight stages in his life-cycle model, with each stage having a normative crisis, a period of heightened vulnerability, and potential. As Erikson explains, each stage builds upon what has gone before and carries elements of itself into future stages. He believes that all people are involved in all the stages all of the time, meaning that throughout our lives, we continue to deepen our first stage of basic trust or faith.

For each of Erikson's major stages, there are seemingly two contrary dispositions which, ideally, are somewhat balanced. In the infant stage trust and mistrust, if in balance, create the basis for hope—which must be awakened by the caregiver. The second stage is early childhood's shame and doubt, which need to be balanced by autonomy and which, together, establish the basic strength of will. The third stage, the play age, fosters the balance between a sense of initiative and a sense of guilt. Out of this, Erikson says, emerges a set of idealized goals and purposes.

School age generates the tension between industry and inferiority, which produces a sense of competence, the basis for cooperative participation in technologies, and the logic of tools and skills. Adolescence is the period of developing one's identity, which is in tension with identity confusion. With resolution, however, a sense of fidelity emerges toward one's own identity, together with an ideological world image. Fidelity is the cornerstone of identity. And this is confirmed by congru-ent ideologies and affirming companionships.

For the young adult, the dominant tension is between intimacy and isolation. Intimacy includes the capacity for eventual commitment to lasting friendships and companionship in general, along with love. Love pervades intimacy and becomes the basis for an ethical concern.

The adult reality of procreating, producing, and creating produces a tension between generativity and self-absorption. A balance between these two produces what Erikson terms "the strength of care."

In the last stage of life, the adult must somehow find a balance between integrity and despair, while achieving wisdom, the desired virtue. As Erikson says:

Wisdom is detached concern with life itself, in the face of death itself. It maintains and learns to convey the integrity of experience, in spite of the decline of bodily and mental functions.

Erikson believes strongly in the principle of "reexperiencing," which allows for healing and integration to occur at any stage. This is especially important, however, during the last stage of life—when remembering and reviewing earlier experiences occur quite naturally.

FAITH AND THE DEVELOPMENTAL CYCLE

If the relationship with the parenting one is trustworthy, the infant develops a trust, an openness, and receptivity in the context of entrusting its life to another. As the child develops, this undifferentiated feeling (that life is basically fulfilling rather than frustrating, and that he or she can rely on the structures of life to be faithful and dependable) can lead to faith which is centered on God as the Faithful One. This response of trust, says
Faith involves a wholehearted acceptance of God as he is disclosed and symbolized in the Bible and in the Christian community.

Cultural heritage and shifts the response of faith from obedience to assent.

Faith involves a wholehearted acceptance of God as he is disclosed and symbolized in the Bible and in the Christian community. It becomes a desire to know God accurately and fully, a need that is met through systematic instruction in the Christian faith. The child seeks to gain closer union with God, moving toward a deeper and more extensive understanding of trust. As this faith extends into adulthood, it becomes an unqualified yes to God, moving the individual into relationship with the Subject of the proclaimed word of faith.

In the struggle for ego identity, the adolescent asks the question, Who am I in relation to the other? With increasing consciousness and reflection, the teenager may also ask, Who am I in relation to God? The resulting faith, as an ultimate identity, has two components: As the adolescent receives confirmation, the need to be recognized and respected as a meaningful and significant person is met. This affirms to the individual that he or she is accepted and forgiven by God. It identifies him or her as an object of God’s unconditional love and as a being of infinite value. This affirmation does away with the need to deny or distort unacceptable parts of the self, and makes possible a sense of continuity that can hold past and present, self and other, possibility and limitation, in some kind of balance. It makes possible a sense of being whole as a result of participation in the healing power of God, revealed in Jesus Christ.

As young adults, individuals are confronted with the challenge of commitment to intimacy, to involvement in a reciprocal relationship which results in a fusing of two separate identities. Through this struggle with unconditional self-giving, the response of faith can become self-surrender. An antidote for self-centeredness, this can result in a total commitment to God as the final source of life and meaning—the losing of one’s life in order to gain it (Matt. 10:39).

The successful giving of oneself to another moves the young adult to the next challenge: contributing to humankind. This may specifically mean the production and care of children. The tension in this stage is between unselfish caring, in which the needs of the significant others become a matter of utmost importance, versus a sense of stagnation, boredom, and self-indulgence. Here, a shift...
from self-surrender to caring takes place. As an act of faith, one may also have a concern for doing the will of God through sacrifice and service to others.

In the tension between integrity and despair, Erikson’s final stage is negotiated successfully when there is a genuine acceptance of one’s life as it has been lived and experienced. The previous unconditional caring gives way in this last stage of life to unconditional acceptance. The elders who were interviewed in the study described themselves and their older friends as more tolerant, patient, open-minded, understanding, compassionate and less critical than when they were younger.

But at the same time, it was noted, there can be a sense of despair, dominated by a feeling of hopelessness and incompleteness. Later life can bring realistic reasons for experiencing despair: a past one wishes had been different, aspects of the present that cause pain, and a future that is uncertain but, most certainly, will include death. Thus, despair must be acknowledged as a possible component of old age.

Erikson also describes this last stage of the life cycle as a time for integrating maturing forms of hope, will, purpose, competence, fidelity, love, and care, into a comprehensive sense of wisdom. The wisdom that is associated with maturity and the final stage of life is both a psychological and spiritual phenomenon. Although Erikson’s data revealed that spiritual growth occurs throughout the life cycle, recent studies have found that religious commitment does tend to rise with age. In the elderly, faith maturity and faith gain is more normative than faith loss. This caring for oneself must be balanced with caring for others. And caring for others comes most naturally in those areas in which individuals themselves have received the gift of healing. For instance, the philosophy of Alcoholics Anonymous is for one alcoholic to care for another. Those healed hurts become compassion when related personally to another person with a similar need.

Intercessory prayer is another manifestation of caring, in which a person asks to know the heart of a friend or family member, in order to pray accordingly. Prayer may also involve releasing a matter to God, or accepting forgiveness from God, in order to be able to extend it to another. Sometimes people have difficulty trusting their mistakes to a God who heals and whose care can create new life after any type of hurt or pain. Mentoring others to develop their own gifts so they no longer need the mentor is another important way of caring. Many find great satisfaction from volunteering their time for people who have experienced a trauma similar to their own (such as losing a child or a mate, surviving a rape or attack or sexual abuse, 2 Cor. 1:4).

The following prayer was found at the Ravensburg death camp where 92,000 women and children died in the Holocaust caused by the Nazi regime. The note was scrawled on a paper wrapping near a dead child:

Lord, remember not only the men and women of good will but also those of ill will. But do not only remember the suffering they have inflicted on us; remember the fruits we have brought, thanks to this suffering—our comradeship, our loyalty, our humility, the courage, the generosity, the greatness of heart which has grown out of all this, and when they come to judgment, let all the fruits we have borne be their forgiveness.

This prayer illustrates the sense of connectedness with all humankind that comes with the wisdom of full maturity.

The disciples on the Emmaus road moved from despair to integrity and wisdom when they walked with Jesus. As he shared...
with them from the Scripture, he tried to show them how even the experience of his death would be lifegiving—part of the plan God had for humankind.

Human beings are challenged in this final stage of life to find the gifts of integrity and wisdom as they face their personal losses and their own death. Ultimately, all must find God's gift in losses. The sooner a person asks, What must I do before I die? the more meaning life will have. This question, along with What is really essential in my life? are questions that must be resolved.

Reminiscing about one's life is an important experience in the process of achieving integration. People may need to come to terms with life's unfinished business as they also become aware of the legacy they are leaving.

Sometimes a dramatic change must occur in order for one to accept death peacefully. For example, Alfred Nobel, of the peace prize fame, mistakenly saw his obituary published when his brother died. He was shocked to realize that he might only be remembered for enabling armies to produce mass destruction, because of his development of modern explosives. He set about to change that by establishing the Nobel Peace Prize, to reward efforts that benefit humanity.

It is not always possible to change everything we want to change, so every hurt and unhappy memory must be placed in God's almighty hands. As we pray for integrity and wisdom, God deepens our ability to love as Jesus loved, unconditionally, and to accept that love for ourselves. Integrity also includes accepting the limitations of our parents and enables us to let go of our wish that they had been different. It also helps us accept the fact that our life has been our own responsibility.

Although our essential self is ageless, the knowledge that all living people are destined to become old will enable us to accept our humanness. Aging, however, is like exploring an unknown country. In his book, Faith for the Older Years, P.B. Maves concluded:

Death is a final healing of that which is hurt and broken, the renewal of that which is worn out, the completion of that which is only partially finished. That which is imperfect is made whole again in the promise of our life being changed, never taken away. Just as everyone has their own style of living, many have their preferred style of dying. The need to prepare for dying is designated by Koenig as one of 14 spiritual needs. Although older people do not often appear to be fearful of dying, death is the loneliest thing human beings do. Many people fear being alone at the time of death. The fear of experiencing pain in the process of dying is also a reality. The fear of death seems universal, to some degree, even though it is often denied. Even Christ wrestled with the dread of death.

But for the Christian whose eternal hope is in Jesus Christ, death is merely a transition. Ultimately, Jesus' death on the cross makes Christians victorious over the one who has held power over death, although this power won't be completely experienced until the Resurrection. Then Christians will claim the release from slavery to the fear of death that has been promised in Hebrews 2:14-15. As Paul says in First Corinthians, "Death has been swallowed up in victory," a victory Christians share in Jesus Christ (1 Cor. 15:54-57). This promise of God not only provides meaning for the last stage of life but provides a source of ultimate peace, and allows all Christians to say with Paul:

Don't fret or worry. Instead of worrying, pray. Let petitions and praises shape your worries into prayers, letting God know your concerns. Before you know it, a sense of God's wholeness, everything coming together for good, will come and settle you down. It's wonderful what happens when Christ displaces worry at the center of your life. .. and God, who makes everything work together, will work you into his most excellent harmonies. I don't have a sense of needing anything personally. I've learned by now to be quite content whatever my circumstances. I'm just as happy with little as with much, with much as with little. I've found the recipe for being happy whether full or hungry, hands full or hands empty. Whatever I have, wherever I am, I can make it through anything in the one who makes me who I am.

(Philippians 4:6-13, paraphrased by Eugene Peterson)

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can nurture such growth. Pastors, Christian educators, counselors, clinicians, other professionals, and all disciples of Christ can stimulate their own growth while also helping others to grow spiritually through such means as prayer (for which many older people have more time than ever before), Bible reading and study, giving themselves in service to God and other people, meditation upon God’s goodness, sharing life experiences (both good and bad) as examples of God’s providential guidance through life, authentic humor that articulates faith and trust, and spiritually oriented reminiscences and life review. All of these can contribute to the attainment of shalom, the holistic well-being of peace with God, others, and self that indicates attainment of the highest possible level of spiritual maturity.

CONCLUSION

Spiritual maturity is a vast subject that is a central target for Christian ministry. Spiritual hunger is more evident in America today than it has been for decades. This offers great opportunities for Christian evangelism and service, but it is accompanied by the danger of syncretizing Christianity with worship of the false gods of other religions. The use of Christian or biblical terminology by New Age and other pagan philosophies does not make them Christian, nor does it justify bringing their teachings into Christian groups. The basic resource for Christian growth is the wealth of guidelines and principles that are found in the Bible. As experts on it, Christian pastors, counselors, and therapists are the “spiritual diagnosticians” who can guide people of all ages toward spiritual maturity.

ENDNOTES

13. Far too often what is professionally called “holistic well-being” has a huge hole in its center, for it omits consideration of spiritual realities, especially faith in Jesus Christ, which is central to Christianity.
Faith and Spirituality as a Means of Coping

problems and disabilities. This research has important public health significance, given that the latter population is (a) dramatically increasing in size with advances in health care that are extending survival, (b) consuming more and more health care resources, and (c) more likely to utilize religion as a coping behavior than any other segment of the population. The next natural step is to develop an instrument that provides a comprehensive, detailed assessment of religious coping in medically ill older adults, and then to examine the relationships between specific types of religious coping, health outcomes, and service use.

CONCLUSION
Religious coping is common among hospitalized patients. It is characterized by traditional Judeo-Christian beliefs and behaviors (trust and faith in God, prayer, Bible reading, etc.). Patients more likely to use religious coping are those who are older, married, living alone, those with high social support, better cognitive functioning, African-Americans, those who abstain from alcohol, and those with worse physical illness. Religious coping is inversely correlated with depressive symptoms cross-sectionally and predicts improvement in depressive symptoms over time. What could not be demonstrated, however, is a positive effect for religious coping on survival. One reason why it does not predict longer survival is because religious coping is more common among those with impaired functional status and more severe physical illness (those at greater risk for death). As physical status worsens, religious coping increases. As physical functioning improves, religious coping decreases. These dynamic factors make it difficult to assess whether religious coping enhances survival in medically ill hospitalized patients. We have developed a measure of religious coping that is brief, reliable, nonoffensive, easy to administer, and predicts health outcomes in hospitalized medically ill patients. Future research needs to be directed at developing more specific measures of religious coping in order to identify those aspects of religious coping that are particularly health-inducing.

Coping increases. As physical illness (those at greater risk for death) increases, religious coping decreases. These dynamic factors make it difficult to assess whether religious coping enhances survival in medically ill hospitalized patients. We have developed a measure of religious coping that is brief, reliable, nonoffensive, easy to administer, and predicts health outcomes in hospitalized medically ill patients. Future research needs to be directed at developing more specific measures of religious coping in order to identify those aspects of religious coping that are particularly health-inducing.

Religious coping is... characterized by traditional Judeo-Christian beliefs and behaviors.

and those that might contribute to maladaptation and psychopathology.

This article is reprinted from a paper which was presented on March 20, 1995, at a National Institutes of Health conference on "Spiritual Assessment in Health Care" in Bethesda, Maryland, sponsored by the National Institutes of Health Department of Spiritual Ministry.

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The Church as Community Builder

community in Northeast Minneapolis, just as they have throughout the country. Today, church leaders need to continue their efforts as community builders. Instead of emphasizing shared ethnicity—which can lead to an emphasis on who is different from whom—churches should work to reunite the community by educating newcomers and old-timers about each other, finding ways to introduce them.
to one another, and enabling them to work together.

Further, church leaders need to build healing communities through expanding the effective communities of those in need. They should bring together persons with resources and those in need in such a way that allows care to be given and received. The local church is the most effective force for this, as it works at the neighborhood level. Churches should also work toward helping to heal their larger environments. They need to support efforts presently underway that are attempting to improve urban life.

Local churches must reclaim their traditional roles as the center of the community. The church has always been a place of healing, a place where lives are lived out, where barriers are broken down, and where people find ways to connect with one another. Vital to this reknitting of the community is the need to listen to and learn from the elderly residents, as well as to pay heed to the newly arrived populations, both of whom can help those in the church rebuild community and neighborhood.

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saying a liturgy may stimulate spiritual experiences in the impaired, as these rituals emphasize affective rather than cognitive channels of communication. Like symbols, rituals can reconnect persons with dementia to God by waking up emotional memories of past spiritual experiences.

Reconnection with God and others is clearly possible for persons with dementia. The starting point for ministry is a theology of aging and impairment which rejects societal stereotypes of the elderly and recognizes the contined personhood of those afflicted with dementia. Each human being, regardless of impairments, bears the “image and glory of God” (1 Cor. 11:7) and consequently should never be “cursed” (James 3:9). Relationships with the impaired based on this premise can counter the spiritual crisis of disconnectedness. If those of us who are unimpaired can open ourselves to the wisdom, the surprises, which the impaired have to offer, God will enter into the interaction to communicate love, grace, and forgiveness. We can become vehicles for God’s love to persons with dementia by valuing them, listening to them, affirming them, and taking the time to creatively draw them out on a spiritual level. In moments of connection, of relationship with others and through others with God, I believe it is possible for the person with dementia to experience spirituality as meaning in spite of suffering. We facilitate a continued sense of meaning in persons with dementia when we make them feel valued in spite of their impairment—when we behave in ways that allow them to experience the truth that who they are is more important than what they can no longer do—and when we stop laughing in skepticism, like Abraham, and start looking for life in the midst of the dying process.

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Fuller Theological Seminary's
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- **COMMUNITY ASSISTANCE PROGRAM FOR SENIORS**—provides day care and therapeutic activities for persons with Alzheimer's disease and related disorders and support for their families.

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