UTILIZING A SMALL GROUP TO ALLEVIATE SYMPTOMS OF MILD DEPRESSION IN AN OLDER ADULT POPULATION AT FIRST BAPTIST CHURCH OF HENDERSONVILLE, TENNESSEE

A DOCTOR OF MINISTRY PROJECT REPORT SUBMITTED TO THE FACULTY OF THE TEMPLE BAPTIST SEMINARY IN CANDIDACY FOR THE DEGREE OF DOCTOR OF MINISTRY

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Most of all, my sincere appreciation goes to my wife and best friend, Lynne Luther. Her encouragement made the completion of this project possible. And to my son, Chandler Luther, thank you for understanding the hours spent at the office.
ABSTRACT

In 2011, First Baptist Church of Hendersonville was a congregation of approximately nine thousand resident members, sixteen ministerial staff, and a host of ministries, providing excellent ministry services to the region. Every age group was acknowledged as valuable contributors to the overall ministry. For thirteen hundred members who were age sixty-five and beyond, First Baptist was home. Many were widows/widowers who lived alone, going protracted lengths of time with little contact with the outside world. In a portion of this cohort, symptoms of mild depression were noticeable. Few of them sought professional counseling which was available through the church counseling center.

The purpose of this project was to evaluate the effects of a strategic small group in helping to alleviate symptoms of mild depression caused by grief and loneliness among an older adult church population at First Baptist Church of Hendersonville, Tennessee. The initial assumption presumed that participation in a small grief share group would help individuals develop more effective mechanisms to cope with grief, and alleviate symptoms associated with mild depression and loneliness. With outcomes supporting the assumption, ongoing groups could be fashioned to address the identified need among the older adult population.
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CHAPTER I
INTRODUCTION

In the words of Robert E. Speer, “Christian faith is not the creation; it is the recognition, of the facts. By believing, we do not make anything true that was not true before. We simply bring ourselves into accord with what is and has always been the truth.”¹ To recognize the facts, what is true, was the intent of this project. And, just as in the Christian faith, the ultimate goal was to appropriately act upon those truths to be revealed in such a fashion that was beneficial to the church and brings honor to the Lord.

The church universal is comprised of all the diversity of the peoples of the world. The variety comes in an assortment of colors, languages, cultures, and ages. The collage is fascinating and functional. In most instances, however, entities are best understood by looking at their individual parts, by a sorting out, by an investigation of a particular unit. The project at hand looked at a particular facet of the church, a particular population and cohort, the older adult.

Older adults represent a significant portion of Christian congregational landscapes, but their value is underappreciated, giving reason for the lack of conversation regarding older adults in the context of the church. How older Christians fit in the local assembly is a matter of some debate. Churches are not always adept at helping older adults manage their health or maximize their potential. Some older adults who participate in church life

are functionally depressed. Depression is “characterized by a depressed mood for most of the day, nearly every day, and may be accompanied by feelings of loneliness, sadness, or emptiness.”2 Depressed Christians lack the capacity to function adequately in the life of the church. The project addressed the issue of lonely, grieving, depressed Christians.

The purpose of the project was to evaluate the effects of a strategic small group in helping to alleviate symptoms of mild depression caused by grief and loneliness among an older adult church population at First Baptist Church of Hendersonville, Tennessee. Concurrently, there were three ministry goals. The first goal was to educate ministry leaders. Older church members struggled with issues of grief and depression. Church leaders would benefit from knowing whether tools are available, strategic small groups in particular, which help their elderly population cope more effectively. Secondly, to understand what kind of small groups were palatable to older adults and effective in addressing their problems appeared imperative to adequate ministry. A homogeneous grief share group was tested. The third goal was to discover what small group components were most beneficial in raising the affect of grieving, lonely persons. These were considered important factors for planning a comprehensive mature adult ministry.

Because the project director was the Minister to Mature Adults at First Baptist Church of Hendersonville, the research was of primary importance. The effects of loss, loneliness, grief, and depression were evident on a daily basis. Many older adults were grieved by the loss of a spouse or significant friends. The findings of the project helped to develop a strategy for the Mature Adult ministry in the congregation.

Additionally, the project director earnestly desired to contribute to the field of mature adult ministry in a broad context. The material and subsequent findings were made available to all who were likewise interested in serving mature adults.

The Context

First Baptist Church of Hendersonville

The First Baptist Church of Hendersonville was a sixty-seven year old Southern Baptist Convention congregation of 8,785 resident members and was among the largest contributors to the Cooperative Program. The annual church budget was 9.5 million dollars. The congregation was located on a forty-acre campus. Buildings ranged in age from a four-year-old Family Ministry Center to a twenty-year-old Worship Center. Most of the educational space was ten to fifteen years old. The total square footage was approximately 330 thousand. The worship style was characterized as blended; however, one of the four morning services offered a more contemporary style.

The Senior Pastor and fifteen staff pastors comprised the ministerial staff. Ministerial staff tended to have long tenures at First Baptist. Thirty administrative assistant positions supported the ministerial staff. Practically speaking, the church was elder-led, yet congregational affirmation was sought on major issues such as building projects, annual budget, and certain staff positions.

In January 2004, the position of Minister to Mature Adults was created due to the constant growth in that age bracket. The Minister to Mature Adults was responsible for the pastoral care and discipleship of members who were sixty-five years of age or older.

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3First Baptist Church Hendersonville Automated Church System, (accessed September 6, 2011).
At the onset of the project, 1,293 members comprised the Mature Adult category. Of this number, 749 were both church and Sunday school members, and 484 were church only members. The Ventures ministry was the primary delivery system of ministry to the mature adult population, to the church membership, and to the community at large. Twelve ministry teams were included in the Ventures ministry regularly utilizing over 300 volunteers.

Twenty-one Sunday school classes accommodated this population. Additionally, weekday Bible studies, missions groups, fellowship and recreational opportunities were available. Ministry opportunities abounded. The Ventures ministry was active in the local community, county, state, and beyond. Two mission trips each year, one to Canada and one to West Virginia, were conducted exclusively by the Mature Adult segment of the congregation. A backpack ministry to nine county elementary schools delivered 300 backpacks weekly, with over 3,000 pounds of food, to needy children and their families. Care teams ministered to individuals in hospitals, nursing homes, hospice facilities, and the homebound. Older adults were seen as a vital part of the ministry of First Baptist.

The City of Hendersonville

Located in Sumner County adjacent to Metro Nashville, Hendersonville was a bedroom community of 48,773 residents. The city, situated on Old Hickory Lake, served as a recreational destination for many surrounding areas. Fishing boats and small yachts filled the lake each weekend. Three private country clubs and two public golf courses

provided additional recreational activities. The Sumner County YMCA had been built for ten years, and along with four larger church family ministry centers, gym space was ample. City parks with walking trails were easily available. Country music had significant ties to Hendersonville. The city was known as being the home of Johnny Cash, Roy Orbison, William Lee Golden, and Ricky Skaggs. Taylor Swift was the newest star to call Hendersonville home.

The city was mostly white, 92.9 percent. Over 10 percent, 4,125 persons, of the total population was sixty-five years of age or older. Women comprised 60 percent of that number. Another 10 percent, 4,064 persons, was between the ages of fifty-five and sixty-four years old. Most of the residents lived in single family homes, and the occupancy rate was 97 percent. Hendersonville enjoyed a good economy despite the current market downturn.

The Opportunity

With 1,293 members over sixty-five years of age, pastoral care situations were constant. Hospital and hospice visits were a part of everyday ministry life. Funerals were practically a weekly occurrence. Within the context emotional struggles abounded, however, these older adults reluctantly sought formal counseling through the church counseling ministry. They would sit with their pastor and chat, and they did.

The vast majority of pastoral chats concerned dealing with loss, how to appropriately grieve, and how to carry on as a widow/widower. Coping with loneliness was a reoccurring theme among this age group. Depression was more significant than people were disposed to admit. Grief support groups could have helped many of these individuals; however, older adults tended to exclude themselves from open, therapeutic
grief groups. Steven Rose characterized a small group as “ten to twenty people who share common purposes and goals and meet on a regular basis for fellowship, relationship, interaction, and growth.” ⁵ Although this definition described several kinds of church groups, therapeutic overtones caused some to avoid participation. At First Baptist of Hendersonville older women tended to avoid groups where younger women participated, and older men were especially resistant to seek help in a therapeutic group. To this older generation, counseling, whether individual or group, was viewed as a weakness. Therefore, these depressed and lonely individuals tended to isolate themselves. The self-imposed isolation over time became self-perpetuating, thereby, causing more loneliness and depression.

The Purpose

The purpose of this project was to evaluate the effects of a strategic small group in helping to alleviate the symptoms of mild depression caused by grief and loneliness among an older adult population at First Baptist Church of Hendersonville, Tennessee. The church had an abundance of existing small groups with an assortment of primary purposes. However, no group focused on the emotional needs of an older adult population. The project director believed that a small group would be effective in a secondary purpose, attenuating loneliness among this older adult population.

The project tried the effectiveness of a strategically designed grief group, and the derivative benefit of a small group targeting widows and widowers who were mature adults. The primary focus of the group was to help participants to grieve effectively the

⁵Steven M. Rose, “Breaking the Growth Barrier at Muskogee First Assembly: Facilitating Assimilation and Developing Community through Small Group Ministry” (D.Min. diss., Assemblies of God Theological Seminary, 2008), 7.
loss of their spouse. Secondarily, the project examined the extent to which loneliness and depression were alleviated. The information, when acquired and understood, helped to fashion an ongoing ministry to the target population.

When the mature adult population of First Baptist functioned well, hundreds of volunteers were set free to do the work of the ministry. When people were depressed, they did not function well. The health of the congregation was improved when emotionally well, high functioning older adults participated in congregational life.

**Description of Proposed Project**

During the course of the project the following three questions were answered: How did participation in a strategic small group help to alleviate symptoms of mild depression caused by grief and loneliness? What group components were most beneficial in elevating the mood of grieving, lonely persons? Would members continue some form of group participation past the treatment time frame? A reduction in the reported feelings of depressed mood originating from grief and loneliness was the immediate anticipated outcome for the participants. When this assumption was supported by the project results, a tool to help depressed older adults was identified. Additionally, components of the group that were particularly helpful were discovered.

**The Scope of the Project**

The following segment describes the project details and expectations. The strategy discussed includes a biblical foundation, leadership involvement, participant involvement, curriculum utilization and meeting schedule, evaluation procedures, and prescribed parameters.
Biblical Foundation

The underpinning for the project was the nature and desire of God to promote healing among His people. Healing was a significant theme of Isaiah 53:4-5, “Yet He Himself bore our sickness, and He carried our pains, but we in turn regarded Him stricken, struck down by God, and afflicted. But He was pierced because of our transgressions, crushed because of our iniquities; punishment for our peace was on Him, and we are healed by His wounds.” 6 Sickness is discernable and diagnosable when it presents in the form of spiritual death, physical malady, or emotional trauma. The plan devised by God to remedy the situation was meant to be holistic in nature, making alive dead men, healing the entire man, and restoring man for His own purposes. Matthew Poole stated, “And whereas it may seem an unreasonable and incredible thing, that so excellent and glorious, and so innocent and just, a person should meet with this usage, it must be known that His grief’s and miseries were not laid upon Him for His own sake, but wholly and solely for the sake of sinful men, in whose stead He stood, and for whose sins He suffered.” 7 The peace that was secured through the substitutionary ministry of Christ was first a peace between God and men. Christ was the propitiation for man’s sins. God was satisfied with Christ’s payment for the sins of man and forgives those who belong to Christ.

The peace of God encompasses the spirits, minds, and hearts of all those redeemed by Christ. The peace of God promotes a deep sense of well being in the

6Isa. 53:4-5. (All Biblical References are from the Holman Christian Standard Bible.)

children of God. Healing involves recovering from some form of trauma, not escaping the trauma. The great truth that God is concerned about the spiritual and emotional distress of Christians, and desires to heal them, was central to this project.

Staff Participation

Because the project focused on the needs of older adults within the fellowship of the First Baptist Church of Hendersonville, the responsibility was placed on the project director, the Minister to Mature Adults, to lead in the implementation of the project. Obviously, this responsibility and opportunity were welcomed. The project enabled the conjoining of two passions, counseling those who are in distress according to biblical principles and ministry to older adults who are grieving and lonely. Pastoral care among such a large number of older adults provided ample occasion to minister the grace of God.

A group co-leader helped to facilitate all group meetings and activities. The individual selected to fill this role functioned regularly as a counselor at the church counseling ministry and was well qualified to lead support groups. Additionally, a staff counselor from the Babb Center counseling ministry assisted in collecting pertinent information from each participant before the group began and after it concluded. The administrative assistant to the Minister to Mature Adults functioned as a correspondent to the group, sending out meeting schedules, preparing group materials, and helping with meeting room set up.

The strategic small group for the project met in the accommodations of the Babb Center counseling ministry. The Director of Counseling graciously offered space where several other groups meet on an ongoing basis. His encouragement and support were
invaluable to the project. A desired outcome was that the success of this group would spawn other groups suited for the targeted mature adult population.

Control of the project was exclusively the responsibility of the project director. Implementation additionally involved the aforementioned individuals.

**People Participation**

Group participants were selected from a list of mature adult members of the congregation of First Baptist Church whose spouses had died within the past five years and who lived alone. All participants were women because a homogeneous group was desired for the project. A homogeneous group eliminated the male/female variable that may have skewed the project outcome. Persons who closely, yet did not exactly, match the criteria were accepted on a case by case basis. A preliminary search identified eighty possible participants in the target category. A minimum of eight group participants and a maximum number of twelve was the goal.

Group participants were solicited through the typical venues for announcing activities at church meetings. This approach historically yielded a less than desirable outcome for formulating support groups of any variety. Therefore, an alternative method of solicitation was also utilized. Individuals were selected, called by the project director, and invited personally to participate in the strategic small group. Personal invitations based on personal relationships garnered the greatest response, and made no significant impact on measured outcomes.

Although the group was comprised of twelve individuals, and these individuals expected positive individual outcomes, a crucial factor was that they viewed themselves as a singular functioning group. James Kouzes and Barry Posner in *Credibility* stated,
“Leaders get people to identify themselves as a group and set the expectation that they will share in some long-term benefits.” The effectiveness of the project hinged significantly on the development of a working group dynamic.

Curriculum Utilization and Meeting Schedule

The strategic small group utilized an edited version of the Grief Share materials, a published curriculum widely distributed for small group therapy. Primarily, editing accomplished the purpose of fitting the materials into the time constraints of the meetings. Video sessions included: “Living with Grief,” “The Effects of Grief,” “When Your Spouse Dies”, “God’s Prescription for Grief,” and several other related topics. Each video clip was discussed by the group, giving participants an opportunity to share their experiences and minister to one another. In addition to the primary teaching tool, group meetings included a module of topic-related Bible study and prayer presented in the manner of a devotional time. Finally, a time for unstructured fellowship and personal interaction were provided and encouraged.

The group met weekly on Tuesday mornings for one and one half hours. There were ten scheduled meetings, although group members were free to choose to meet together outside of the prescribed parameters of the group. Sessions occurred in the conference room at the Babb Center, the church counseling ministry, located on the church campus.

Evaluation Procedures

Two instruments were selected to assess self-reported depressed mood caused by grief and loneliness in the target older adult population. Both instruments were credited for being easily administered and relatively short, yet had a well established reliability. These tools were The UCLA Loneliness Scale and the Beck Depression Inventory II. They were cost effective and were typically administered and interpreted by persons with a counseling psychology background.

The UCLA Loneliness Scale consisted of twenty questions with the participants choosing one of four possible responses. It was developed to measure subjective feelings of loneliness. The instrument was user friendly with an elderly population. The anticipated administration time was five minutes.

The Beck Depression Inventory II consisted of twenty-one groups of statements with four possible responses for each item. The instrument was probably the most widely utilized instrument for detecting depression in the United States. The inventory was user friendly with populations from adolescent throughout the lifespan. The anticipated administration time was ten minutes.

Instruments were administered and interpreted by a staff psychological examiner from the Babb Center, the counseling center at First Baptist Church of Hendersonville. Information was gathered prior to the group experience and after the group concluded.

In addition to those instruments, each participant was asked to complete a simple evaluation of the group experience on a weekly basis. The quality and perceived helpfulness of the social time, devotional and prayer segment, video component, and the discussion time was rated by each participant. At the conclusion of the group experience, each participant was asked to complete an evaluation of the group experience addressing
the following six questions: Do you feel better than before starting the group? Were you encouraged by the group? Did you develop new relationships with group members? Did the group help you cope with grief more effectively? Would you consider continuing to meet past the treatment schedule parameters? Would you recommend a similar group to a friend?

At the culmination of the project, a counseling appointment with the project director was made available for each participant. The primary focus of the appointment was to debrief the participant. Pending significant findings from the self-reported information, the group sessions, or during the debriefing session, subsequent counseling sessions were made available to the participants.

The project director understood and assumed the possibility of the Hawthorne Effect during the project. The participants could have behaved differently simply because they were being observed without actually making significant internal changes. Throughout the project there was no observable indication that the Hawthorne Effect skewed the results. A group of five individuals who meet the support group criteria was established. They reported their experiences of depression and loneliness but did not participate in the support group process. Their information juxtaposed the support group participant information for comparative purposes.

**Prescribed Parameters**

Group participants met prescribed parameters as follows: each participant was female and older than sixty-five years of age, had been widowed within the past five years, lived alone, and was a member of the congregation. Slight deviations from these parameters were considered on a case by case basis and intensely scrutinized.
Phases of the Project

The project involved five phases: research, planning, implementation, evaluation, and writing. Each phase was assigned a corresponding time frame in order to facilitate the advancement of the project. J. Oswald Sanders in *Spiritual Leadership* said, “A leader is a person who has learned to obey a discipline imposed from without, and has then taken on a more rigorous discipline from within. Those who rebel against authority and scorn self-discipline, who shirk the rigors and turn from the sacrifices, do not qualify to lead.”

Maintaining the order and schedule of the project involved discipline that proved crucial to the completion and the validity of the project.

**Phase 1 – Research**

The first phase involved detailed research in three spheres: (1) a biblical-theological review, (2) a general literature review, and (3) a search for an appropriate treatment modality for use among older adults.

Biblical-Theological Review

This section included a rehearsal of the general aging process as described in the Bible, the spiritual contributions of older adults, and a picture of grief and loneliness. The nature of the church as one body, the church as community, and healing within the church were surveyed as they related to the holistic healing of God. An examination of those topics gave a solid foundation for better understanding the challenges of old age and the attending difficulties from a biblical perspective.

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General Literature Review

The focus of this portion of the research entailed scrutinizing profiles of older adults in America, including lifespan issues, a survey of circumstances involving grief and loneliness among older people, and the attending depression frequently accompanying these issues. Moving toward alleviating those negative symptoms involved investigating therapeutic interventions for grief, group processes and dynamics, and the benefit of socialization among older adults.

Although ageism and discrimination were not the primary focus of the project; those unfavorable factors influenced the type of information available and the particular viewpoint from which materials were written. These issues were addressed as ancillary material in the general literature review.

Phase 2 – Planning

The second phase included (1) the selection of treatment and investigative tools, (2) selection of leadership in addition to the project director, and (3) coordinating facilities for group meetings. Those components were vital to the success of the project and necessary prior to action being taken.

Selecting Treatment and Investigative Tools

The population examined was older adults, which necessitated devising a treatment modality that best suited their particular needs. First, identifying an appropriate method and curriculum for treatment was determined. Next, identifying accompanying instruments for gathering participant information was necessary. Investigative tools included self-reported depression and loneliness experiences, a rating system for individual meetings, and an overall evaluation of the therapeutic group experience.
Selection of Leadership

In addition to the project director, proper facilitation dictated the necessity to acquire a co-leader for the group. This individual needed adequate counseling experience, group dynamic skills, and preferably female in order to balance group leadership and to offer perspective. Several possible candidates were available through the Babb Center counseling ministry.

The administrative assistant to the Minister to Mature Adults acted as correspondent between the group facilitator and the treatment group. Prior rapport with several of the group members was established and regular communication helped to facilitate group retention.

Coordinating Facilities

This matter entailed more than one may anticipate. Since this group was comprised of mature adults who did not traditionally participate in professional counseling, logistics were taken into consideration. Rooms in the church educational building were available; however, they were set up as classrooms and did not provide the desired environment. Whether or not participants would engage in sessions at the church counseling center presented concern. A large conference room in that building was utilized. Group members were asked whether the meeting place was a factor in their decision to participate.

Phase 3 – Action

The third phase initiated the treatment segment of the project. The group began meeting on September 27, 2011 and continued through December 13, 2011. The time
frame provided for ten group meetings with two off weeks to accommodate holiday schedules. Meeting days were on Tuesday morning from 10:00 a.m. to 11:30 a.m. The meeting time accommodated group luncheons as desired by the participants.

**Phase 4 – Evaluation**

The fourth phase involved the appraisal of the information acquired during the treatment segment of the project. Evaluation of the project began after the first group meeting when participants self-reported their levels of depression and loneliness and was completed on the final week when participants repeated the self-report. The results from these reports were compiled by the psychological examiner and given to the project director. Throughout the course of treatment, members completed evaluations of the effectiveness of each group meeting. The report information was compiled by the project director at the conclusion of the treatment segment of the project.

**Phase 5 – Writing**

The fifth phase encapsulated the research, methodology, treatment, and outcomes derived from the project. Chapters 1 and 2 which contain introductory materials and the literature review were completed in November 2011. Chapters 3 and 4 which contain a description of the field project and a project summary were completed in December 2011.

A preliminary draft of the project was submitted on January 15, 2012. The final revision of the Doctor of Ministry Project Report was submitted on March 15, 2012.
Conclusion

The contributions of older adults to American society have been significant. Yet, negative stereotypes of older persons, and the challenges associated with advanced age, have contributed to various forms of ageism, even among Christian communities. In many congregations, and certainly among the congregation of First Baptist Church of Hendersonville, mature adults represented a significant driving ministry force. At the time of the project older adults were collectively the greatest contributors of resources including financial, man hours in direct ministry, experience, and leadership. Moses spoke to the nation of Israel concerning their older adults in Leviticus 19:32, “You are to rise in the presence of the elderly and honor the old. Fear your God; I am the Lord.” Honoring the elderly among them was not optional.
CHAPTER 2

LITERATURE REVIEW

Introduction to Biblical-Theological Review

When David penned the words, “I have been young and now I am old,” he was matter-of-fact.\(^1\) The declaration was not particularly a testimony of lament but simply a statement of the obvious nature of change in the lives of humans. The great king was not exempt from the experience of aging. Some questions, however, naturally arise. For instance, “When exactly does one become old?” The answer may be relative due to the changing realities of societies, but attempts are nevertheless made to quantify the process. A large number of individuals would agree, particularly the very young, that the onset of old age begins between sixty and sixty-five. The next twenty years are called “young old age,” and only past eighty-five are people the “oldest old.”\(^2\)

Another question concerns the consequences of the process itself, “What can one reasonably expect to happen in old age?” Gary Collins in *Christian Counseling* said, “As we get older our bodies run down, but some bodies decline sooner and more quickly than others.”\(^3\) The picture became bleaker as he further listed problems associated with

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\(^{1}\)Ps. 37:25.


\(^{3}\)Ibid., 216.
aging grouped in categories of mental, economic, and spiritual issues. Although he was factual, both the condition and the prognosis appeared to be quite poor. In this light therefore, an open and honest review of the aging process begged attention. A biblical theology in regard to aging, the adverse consequences of the aging process and the potential for help to attenuate those consequences follow.

**Aging in a Scriptural Context**

Solomon stated in Ecclesiastes 12:1, “So remember your Creator in the days of your youth: before the days of adversity come, and the years approach when you will say, ‘I have no pleasure in them.’” Gary Collins quoted G. Stanley Hall as remarking about this passage, “This is the most pessimistic description of old age ever written, but it also is realistic.” The reality of aging was clearly seen, from a particular perspective, in Ecclesiastes 12:2-5. Words and phrases such as “before the sun and light are darkened, see dimly, while the sound of the mill fades, all the daughters of song grow faint, and mourners will walk around in the street” cannot be mistaken for an omen of good outcomes. The latter years of the aging process provide fertile ground for all sorts of ailments and frailty associated with decline.

Several Old Testament passages refer to the loss of sight, perhaps one of the most dreaded complications of old age in any historical context. Moses says in Genesis 27:1, “When Isaac was old and his eyes were so weak that he could not see, he called his older son Esau and said to him, ‘My Son.’” Jacob took full advantage of his father’s diminished eyesight and stole his brother Esau’s blessing. This story became a primary

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example for the exploiting of feeble elderly persons and for utilizing unscrupulous means to get a desired result. What has sometimes been overlooked was a fact that Warren W. Wiersbe called to attention, “Isaac is now about 137 years old, yet he acts as though he will die. Actually, he lived to be 180. His impatience to give Esau the blessing suggests his own carnal plans, not God’s will.” This insight changed the manner in which the characters in this account were viewed. Jacob took advantage of an old man’s sensory deprivation, but God allowed Rebekah to hear the conversation between Isaac and Esau for the specific purpose of altering the outcome. Years later Jacob found himself in a similar condition as described in Genesis 48:10, “Now Jacob’s eyesight was poor because of old age; he could hardly see.” In this story Ephraim received a greater blessing than his older brother Manasseh, yet there were no overtones of trickery by the boys or their father Joseph. Jacob’s failed eyesight played no part in the transaction; nevertheless, the diminished ability to see was again portrayed as a negative part of the aging process.

King David provided a glimpse into the life of a seventy year old man whose physical condition was in a state of severe decline. The writer of 1 Kings 1:1 said, “Now King David was old and getting on in years. Although they covered him with bedclothes, he could not get warm.” Merrill F. Unger commented:

> Although only in his seventieth year, he was prematurely aged. His physical condition is introduced here because the succession to the throne is the subject broached. The king’s strenuous life, the exposures and hardships of his youth, the cares and anxieties of his reign, the chastening through which he had passed on account of his great sin, and many other things were responsible for his enfeebled condition.  

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This description was reasonably fitting of someone much older than David who was merely seventy years old. The writer stated in verse 4, “She served him, but he was not intimate with her,” to which Unger commented, “The passage only states that the king could not get warm physically, but it implies that he was too weakened to be aroused sexually.” This inability marked either a state of poor health and disease prematurely or a juncture in the lifespan that signaled that he was simply too old to engage in sexual activity and procreation.

The writer offered additional insight in 1 Kings 2:1 when he said, “As the time approached for David to die, he instructed his son Solomon.” Matthew Poole commented, “‘Stricken in years’, being in the end of his seventieth year, he ‘gat no heat’, which is not strange in a person not only of so great an age, but also who had been exercised with so many hardships in war, and with such tormenting cares, and fears, and sorrows, for his own sins, and for the sins and miseries of his children and people.’”

Persons studying the life of David have good reason to presume that his life struggles contributed heavily to his ultimate state of physical decline. The stress of life under Saul, the responsibility of being king, the weight and consequences of sin, and the heartache of rebellious children took a predictable toll on the duration of his lifespan. Although God sustained him in battles against beasts and giants, foes from within, and armies from without, David eventually felt the grip of old age and the accompanying physical decline prior to his death.

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7Ibid.

8Poole, 645.
In Genesis 3:8, the Lord God was characterized as “walking in the garden at the
time of the evening breeze,” and by implication, Adam and Eve were accustomed to
walking with Him in perfect fellowship. “Walk” was a metaphor for obedience and
faithfulness in many passages. For instance, Moses asserted in Genesis 5:22, “Enoch
walked with God 300 years.” Moses said in Deuteronomy 11:22, “Love the Lord your
God, walk in all His ways.” When one is unable to walk, one usually experiences grief.
The connotation is negative. Frailty is indicated when walking is not possible for an
individual. Frequently associated with old age is the inability to walk without the
assistance provided by a cane or staff. A striking juxtaposition was portrayed in
Zechariah 8:4-5, “The Lord of Hosts says this: ‘Old men and women will again sit along
the streets of Jerusalem, each with a staff in hand because of advanced age. The streets of
the city will be filled with boys and girls playing in them.’” In the text the old people sat
because they could not walk. They were reduced to being spectators. The children played,
ran and jumped, an activity far more strenuous than walking. The passage positively
addressed God’s unfailing love for a people who were frequently unfaithful and His
desire and commitment to restore a remnant people for His further purposes. The truths
of the passage were less positive in the light of what was possible in youth verses what
was possible in old age. Matthew Poole took the more positive approach when he said,

Formerly war, or famine, or pestilence and wasting diseases, or wild beasts did cut off
men and women before they grew to old age, but now it shall be otherwise, I will bless
with health and long life in a peaceful state. This old age shall be a crown of honor to
this city. It shall not be from weakness and diseases that they lean on their staffs, but
very (old) age shall bring them to it.⁹

⁹Ibid.
One may assume that at the end of the day the children ran home to their parents. The old men and women collected their staffs and leaned on them as they shuffled home and remembered when they too ran.

Certain passages are encouraging and uplifting regarding old age. The psalmist wrote, “They will still bear fruit in old age, healthy and green” (Psalm 92:14). One may anticipate satisfying experiences in old age. Gary McIntosh in *One Church Four Generations* said, “people have done their greatest work in old age.”[^10] The life of Moses gives ample illustration of God using people through all stages of their lives. The first third of Moses’ life was spent in Egypt, the middle third in Midian, and the last third leading the people of God through the wilderness to land that God had promised to them. The trials of each segment of the life of Moses were demonstrated.

In Deuteronomy 34:7, this description of Moses in old age was given: “Moses was 120 years old when he died; his eyes were not weak, and his vitality had not left him.” That the Lord sustained Moses for the task he was called to accomplish was never in question; however, this passage was a statement of enablement of the body and spirit of an old man. Matthew Henry said, “His life was prolonged to old age. He was one hundred and twenty years old, which though far short of the years of the patriarchs, yet much exceeded the years of most of his contemporaries, for the ordinary age of man had been lately reduced to seventy.”[^11] Not only were his days prolonged but his stamina had not suffered significant decline. Henry further stated, “there was no decay either of the


strength of his body or of the vigor and activity of his mind, but he could still speak, and write, and walk, as well as ever. His understanding was clear, and his memory as strong as ever.”\(^{12}\) Regardless of the circumstances surrounding the extended years and sustained physical acuity in the life of Moses, the outcome may rightly be viewed as positive. The Lord caused a man to be able to function past his typical duration in order to continue to serve and fulfill his purpose in life.

No wholesale guarantees exist for a specific number of years of life. However, some passages demonstrate correlation, if not causality, between a right relationship with the Lord and prolonged days of life. For instance, Moses wrote in Exodus 20:12, “Honor your father and your mother so that you may have a long life in the land that the Lord your God is giving you.” The fifth of the Ten Commandments carried a blessing for those who obeyed. The blessing was longevity. The writer of 1 Kings 3:14 stated, “If you walk in My ways and keep My statutes and commandments just as your father David did, I will give you a long life.” Solomon was the recipient of this promise from God in the form of a dream. After he awoke, Solomon proceeded to offer a sacrifice and held a feast. He delighted in the promise given to him by the Lord. In Proverbs 10:27 Solomon said, “The fear of the Lord prolongs life, but the years of the wicked are cut short.” The passage revealed two alternatives and corresponding consequences, one positive and the other negative, both in regard to the length of one’s life.

Although no two people experience exactly the same phenomenon, most people within a group have related experiences. McIntosh suggested that as a generation moves through time together, they experience similar events. This phenomenon often results in

\(^{12}\)Ibid.
the cohort adopting similar ways of thinking and feeling. Group similarity is sometimes the basis of making generalizations and forming stereotypes, these similar tendencies provide a way to examine the characteristics of groups of people and learn from them. For instance, regarding the now seventy to eighty-year olds one may say, “They do things because they believe it is right to do them.” Thus, through a generalization an accurate picture of a group is understood. Similarly, a generalization regarding old age may be made. A reasonable assumption is that many older adults have similar experiences. David gave insight in Psalm 39:5 into what may be the generally accepted reality of growing old, “You, indeed, have made my days short in length, and my life span as nothing in Your sight. Yes, every mortal man is only a vapor.”

Not all aspects of aging are negative all of the time. For people of faith especially, satisfaction can be found in the later years of life. Older people can “bear fruit” by contributing to the lives of others. Many experiences in later life are, however, laced with the bitter taste of decline, and this decline takes the form of physical, mental, emotional, and sometimes spiritual pathology.

**Spiritual Contributions of Older Adults**

Older adults are well represented among those making significant spiritual contributions to their world. Some are known more especially for their contribution than their age, and others more for their age than their contribution. Among the most well known are Adam who lived to be nine-hundred and thirty, Methuselah who was nine-hundred and sixty-nine, Noah who was nine-hundred and fifty, Job who was one-hundred

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13 McIntosh, 30.
14 Ibid., 39.
and forty, Sarah who was one-hundred and twenty-seven, Abraham who was one-
hundred and seventy-five, Joseph who was one-hundred and ten, Moses who was one-
hundred and twenty, Joshua who was one-hundred and ten, and the apostle Paul whom
according to Philemon 1:9 was “an elderly man.” For illustrative purposes, Abraham
represents older persons who made spiritual contributions. Of Abraham, Leon Wood said,
“He was a man of outstanding faith, demonstrated especially in his willingness to leave
Ur of the Chaldees for an unidentified land, and to sacrifice his own son, even believing
God would raise him from the dead to fulfill the promise of a great nation.”¹⁵

Abraham was a great man by any standard of measurement. He stood as an
element of faith, listed among the heroes of the faith in Hebrews 11:8, “By faith
Abraham, when he was called, obeyed and went out to a place he was going to receive an
inheritance; he went out, not knowing where he was going.” The writer of Hebrews
recorded in Hebrews 11:39 that all those individuals he mentioned were “approved
through their faith.” Their faith enabled them to accomplish much. Their actions are
exceedingly well known among Bible students. Actions that are so magnificent that they
are legendary are not, however, the only type of contributions made by older persons of
faith. In fact, notoriety attends few older adults who make a significant impact on those
within their sphere of influence. History records the actions and accomplishments of
great men, but other measurements of great men determine greatness. Bayard Taylor said,
“Fame is what you have taken, character is what you give.”¹⁶

Character is a significant spiritual contribution. Many who have demonstrated

63-64.

proven spiritual character are virtually unknown except by those in their immediate ecology. In Philippians 2:22, Paul wrote of Timothy, “You know his proven character, because he has served with me in the gospel ministry like a son with a father.” Timothy was not associated with any particular great singular event recorded in the Bible. He was known as a faithful minister who fulfilled his duty to God and was a true friend to Paul.

Paul addressed the origin of proven character in Romans 5:4 when he wrote, “Endurance produces proven character.” Paul knew something of enduring hardship for the sake of the gospel and wrote in 2 Corinthians 11:23, “Are they servants of Christ? I’m talking like a madman – I’m a better one: with far more labors, many more imprisonments, far worse beatings, near death many times.” Paul rehearsed his experiences in order to make a point regarding his apostolic authority, not to draw attention to himself. He saw his suffering as a defense of his apostleship. He built a resume of character, not necessarily accomplishments. D. Edmond Hiebert, in An Introduction to the New Testament – Volume Two the Pauline Epistles wrote, “The marvelous catalog of his experiences given in this passage reveals clearly how much there was in the arduous life of the Apostle that remains entirely unknown to us.”

Paul’s life demonstrated his willing nature to suffer grueling hardship for the sake of becoming in character, like Christ. Both endured great hardship over a period of time. John Pollock, in The Apostle, described a stoning that Paul survived in Lystra, “In a moment, before Barnabas or his friends could protect him, he was under a shower of stones, on his jaw, the pit of his stomach, his groin, his chest, his temple. He fell stark and

stiff, blood streaming from nose and eyes.” Paul was qualified to speak concerning “proven character.” He endured, perhaps more than any other disciple, the wrath of those antagonistic to the gospel of Christ. He earned the right to speak regarding legitimate expectations of conduct and character in the lives of believers.

Paul addressed character traits that are normal and expected among older men in Titus 2:2, “Older men are to be self-controlled, worthy of respect, sensible, and sound in faith, love, and endurance.” Marvin Vincent made clear to whom Paul was referring when he spoke of “older men,” meaning they were “to be understood of natural age, not of ecclesiastical position.” William Hendriksen agreed when he said, “The greybeards should have the same moral characteristics as the elders and the deacons.” Being an older man carried certain expectations for conduct and character. These character traits differentiated older and younger persons because younger persons had neither the time nor the experience of older adults. The primary contributions of older persons were lives distinguished by soundness and fundamental goodness that was enduring in nature regardless of the temporal situation. Paul raised the proverbial bar of expectation for older men and called on them to set the example for their younger counterparts.

Paul began with the admonition to be “self-controlled.” W. E. Vine suggested that the term “denotes of sound mind” and carries a meaning of sobriety and temperance.

Moderation and reasonableness of conduct were in view, as opposed to the more excessive and extreme tendencies of younger men. When Paul listed the fruit of the Spirit in Galatians 5:22-23, “self-control” was included. He then added in 5:24 “Now those who belong to Christ have crucified the flesh with its passions and desires.” Passions and desires often wreak havoc on young men; however, older men should demonstrate a control of those passions, placing the love of Christ as their primary desire.

The next character trait was “worthy of respect.” James Strong denoted the meaning as that of being “venerable or honorable.” Paul insisted that the older men should so conduct themselves as to be admired and esteemed by those who observe their behavior. In Deuteronomy 1:13, Moses told the Israelites to “Appoint for yourselves wise, understanding, and respected men from each of your tribes and I will make them your leaders.” Older men want to live in a fashion that made them worthy of high regard. Younger men want to observe the lives of the older men and see something worthy to emulate.

Older men were to be “sensible.” F. Wilbur Gingrich in *Shorter Lexicon of the Greek New Testament* defined the Greek word to mean “prudent or thoughtful.” The meaning connoted that which was rational and judicious. The term described the person who exercised good judgment in a situation. Solomon offered context in Proverbs 13:16, “Every sensible person acts knowledgably, but a fool displays his stupidity.” He described the discernment of “sensible” men in Proverbs 14:15, “The inexperienced believe anything, but the sensible watch their steps.” Sensible men considered options

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and alternatives and proceed with caution. This behavior contrasted with the imprudent and impetuous nature of young men and came with age and experience.

The final character quality that Paul urged Titus to remind the older men of was “sound in faith, love, and endurance.” The meaning of “sound” had to do with being solid and unyielding. In Proverbs 18:1, Solomon warned, “One who isolates himself pursues selfish desires; he rebels against all sound judgment.” Soundness was to be demonstrated in the areas of “faith, love, and endurance.” Hendriksen commented, “Their faith, in order to be sound, must be neither luke-warm nor mixed with error. Their love must not deteriorate into sentimentality nor must it be permitted to wax cold. And their endurance must not be replaced by either faint-heartedness on the one hand or obstinacy on the other.”24 These characteristics were not customary in a neophyte Christian. They came only with the endurance of hardship and time. Barnes summed up the thought when he said, “He should have overcome, at his time of life, all the fiery, impetuous, envious, wrathful passions of his early years, and his mind should be subdued into sweet benevolence to all mankind.”25

Older adults have made major contributions to their world. They have done things worthy of being recorded in history texts, and some have become legendary. The apostle Paul gave an example of suffering throughout his lifetime, especially in his older age, for the cause of Christ. His trials and tribulations were well-documented throughout the New Testament. Although the number of those well known for their contributions is substantial, many heroes remain anonymous. They were not associated with any specific

24Hendrikson, 363.

act of renown or greatness. They were heroes not to the masses but to those among whom they lived a quiet and focused life. Their contribution was their example of faithfulness and their encouragement to others to live likewise. Theirs was a significant spiritual contribution.

Age Related Loneliness

The plans of God are moral (right) and ideal (good) because God’s nature is both moral and ideal. As Creator, the design and operating capacity of humans are fully known by Him. He understands His creation. In that light, Genesis 2:18, “Then the Lord God said, ‘It is not good for the man to be alone. I will make a helper who is like him’” declared that the ideal (good) was for man to have a counterpart. In his book Soulcraft, Douglas Webster wrote, “God designed us in such a way that the measure of our communion with Him is reflected in the depth of our relationships with others.”

Relationships are critical to wellbeing and well functioning. Cloud and Townsend advanced the thought when they wrote, “Loving God and others is the end result and purpose of basically any good activity.” Significant relationships are important in the lives of humans.

The apostle Paul experienced the loss of significant relationships while incarcerated in Rome. Although he had been weathered and seasoned by a litany of prior hardships, he suffered considerable personal emotional pain. Granted, his hurt was more attributed to the situation of the incarceration than of old age, since he was in his early


sixties, yet, the sense of being alone was understood and communicated in a universal fashion. He explained his feelings to his younger apprentice Timothy in 2 Timothy 4:9-10 when he wrote, “Make every effort to come to me soon, for Demas has deserted me, because he loved this present world, and has gone to Thessalonica. Crescens has gone to Galatia, Titus to Dalmatia.” Marvin Vincent in Vincent’s Word Studies of the New Testament explained, “The compounded preposition indicates a condition or circumstance in which one has been left, as the common phrase ‘left in the lurch.’” This situation was quite different from simply being alone. Being left alone for a relatively short period of time during normal circumstances is not at all unusual. Adults regularly deal with those situations. Paul communicated something different. He was left in a difficult and extraordinary situation, and no one was present to help him. Paul’s request for Timothy to “come to me soon” revealed his emotional pain, feelings of loneliness, and a sense of urgency. William Hendrikson commented, “Hence, all the more pathetic are these plaintive words.” One would hardly think of the apostle Paul as “pathetic.” He faced so many obstacles with resilience. Yet, during a period of loneliness he appeared to be melancholic.

A more typical context of loneliness was presented in 1 Timothy 5:5, “The real widow, left all alone, has put her hope in God and continues night and day in her petitions and prayers.” Albert Barnes noted, “The sense was that she had no children or other descendents; none on whom she could depend for support. She had no one else to look to but God. She had no earthly reliance; and, destitute of husband, children, and

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28Vincent, 324.
29Hendrikson, 318.
property, she feels her dependence, and steadily looks to God for consolation and support.”\(^{30}\) William Hendriksen observed, “The real widow, then, has nowhere else to go! Her refuge is the living God, for on earth she is no one’s dependent.”\(^{31}\) This situation was more apt to occur because of the natural ageing process than because of special circumstance. Although the situation was undesirable, the outcome had positive connotations. The true widow, who was spiritually minded, reached out to God in dependence. That connection was vital and sustained her through her troubles. Nevertheless, the loss of humans on whom she could rely made loneliness likely. Humans were made for relationship with God and one another.

Through the process of aging and eventually death, relationships are broken. Larry Crabb suggested that the consequences of these broken relationships are severe, and remarked, “We were designed to connect with others: Connecting is life. Loneliness is the ultimate horror.”\(^{32}\) This reasoning is consistent with Psalm 25:16, “Turn to me and be gracious to me, for I am alone and afflicted.” Negative consequences were associated with being lonely. Gary Collins described it this way, “Loneliness is the painful awareness that we lack close and meaningful contact with others. It involves a feeling of inner emptiness, isolation, and intense longing.”\(^{33}\) Regardless of the reasons for being lonely the outcomes are quite negative. Being lonely is contrary to the original plan for humans. Adam and Eve were never alone or lonely until one of them died. Collins

\(^{30}\)Barnes, 1152.

\(^{31}\)Hendrikson, 169.


\(^{33}\)Collins, 93.
commented, “Friends and relatives, including one’s spouse, often die and leave surviving older people without peers to bolster morale.”34

Through no particular fault of an older person, no selfish demands, no unrealistic expectations, relationships are broken. When people age and die others are left alone and lonely. The one left behind may feel as if he or she no longer fits, and may “lack a sense of belonging, feel isolated, lonely, unwanted, and often unable to trust.”35

Loneliness can foster other related emotional difficulties. For instance, the fear of developing new relationships may occur. Charles Stanley suggested that “God never intended that we live in fear that keeps us from seeking deeper relationship with Him or that keeps us from going about normal daily life or fulfilling the responsibilities we have to others.”36 Crabb called the result of this fear a “retreat to empty living.”37 Fear can render the older person helpless. Loneliness that leads to fear can in turn cause isolation that increases loneliness. The problem may become cyclical and feed on itself. Cloud and Townsend commented, “Many people who are lonely passively sit around waiting for someone to come along or something to happen that will bring them out of their loneliness.”38 When rescue does not occur and time alone does not heal the longings of the heart, older people may “close their heart to others, and feel empty and

34Ibid., 217.


37Crabb, 54.

By design humans are meant for relationship with one another. They function more fully in relationship. Older adults sometimes find themselves alone through no fault of their own. People whom they love die. Loneliness can be debilitating. Pathological thinking and behaving may be the result of prolonged loneliness.

**The Church as One Body**

**Introduction**

The memberships of many congregations are comprised of significant numbers of older people. Congregational profiles reflect both the advantages and disadvantages of disproportionate numbers of mature adults. Similarly, problems arise when there is an imbalance with any one particular age segment. Congregational makeup can adversely influence ministry effectiveness, especially when one portion of the congregation feels a sense of competition with another. Gary McIntosh said, “Some churches today specifically target Boomers or Busters, but for most existing, traditional churches, this kind of narrow focus is not possible. Most pastors and church leaders know that they must work with all generations in the same church without ignoring any of them.”

These are matters of composition, or form. Every type of organization has form. Since the form of an organization particularly influences how it functions, prudence demands that one examine the attending issues regarding organizational form.

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40 McIntosh, 211.
Diversity and Unity

In 1 Corinthians 12:12 Paul said, “For as the body is one and has many parts, and all the parts of that body, though many, are one body – so also is Christ.” The juxtaposition of “one” and “many” is difficult to ignore. Paul emphasized the point again in verse 14, “So the body is not one part but many.” Paul made the point that there was a relationship between the body and the individual. He expressed the conjoint nature of the individual parts of the church. No part existed in and of itself, and no part existed for itself alone. Each part was related by being combined with others to form a whole. The church as a whole had form and, if healthy, functioned properly. F. W. Grosheide in *Commentary on the First Epistle to the Corinthians* said, “It is true, Paul makes his application immediately but in vs. 14 returns to the figurative way of speaking. The point which this figure is supposed to illustrate cannot be the work of the Spirit but rather the truth that unity and diversity quite naturally go together.” That unity and diversity coexist is of importance.

Given that the context is addressing the diversity of spiritual gifts, and not differing ages, one may at a glance think the illustration does not apply. The concept remains the same, however, that there are differences among individual parts, whether spiritual giftedness or age related experiences and abilities. In the church as a body all parts, and ages, go together. When age differences are accommodated for well, the blend is natural and normal. Lewis Sperry Chafer in *Systematic Theology* said, “The context of this passage sets forth the absolute unity or identity which obtains between Christ and the

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members of His Body. The members are a unity, being in one Body, and in its larger meaning this Body when joined to its Head is also one unity – with Christ.” The meaning of the verse is self-evident, individual parts of the body enjoy a symbiotic relationship.

Tension and Fracture

Not all tension is unhealthy. As a matter of fact, poles of tension are evident in the Bible. The writer of Proverbs 26:4-5 said, “Don’t answer a fool according to his foolishness, or you’ll be like him yourself. Answer a fool according to his foolishness, or he’ll become wise in his own eyes.” These verses are not at all contradictory. They do not oppose each other but complement each other. Understood together, they convey the thought that wisdom dictates allowing a fool to be foolish without intervention. On other occasions, prudence means intervention, else the fool will be taken away with his own foolishness and others may be in danger of emulating him. The apparent tension between these two verses is relieved by the appropriate use of discretion.

Ideally, there exists no unhealthy tension among the parts of the body because it produces pathology. Unfortunately, an unhealthy, divisive, and destructive form of tension exists. Symptoms of congregational tension may become obvious as evidenced by attempts at positioning to improve individual circumstances or to promote personal preferences. In 1 Corinthians 6:7, Paul said, “Therefore, it is already a total defeat for you that you have lawsuits against one another. Why not rather put up with injustice? Why not rather be cheated? Instead, you act unjustly and cheat – and this to brothers!”

Tension may cause fracture. Worship style preferences, dissimilarity of vision and direction, and age related differences may contribute to congregational unrest and dissention. McIntosh said, “Not only are there four generations existing together, but there are four sets of value systems that are being advanced each with its perceived needs and perspectives.” Individual differences among members of the body may become contentious if not appropriately considered.

The church at Corinth stood as a sad example of unhealthy tension. In 1 Corinthians 1:11, Paul stated, “For it has been reported to me about you, my brothers, by members of Chloe’s household, that there are quarrels among you.” The body had become divided, sides were taken, and hostility toward one another abounded. This split was mirrored in the text of 1 Corinthians 12:15, “If the foot should say, ‘Because I’m not a hand, I don’t belong to the body,’ in spite of this it still belongs to the body.” Grosheide commented, “Paul then puts into the mouth of the various members of the body statements which are absurd because they failed to appreciate the unity of the body, a unity which cannot be abolished. The foot is right when it says that it is not the hand, for there is a difference between the members, but it is wrong if it does not like to belong to the body simply because it is not a hand.” Unhealthy tension may arise in congregations at any time. Often, tension exists between the various ages represented in the congregation. Older adults may be the object of ridicule and tend to be stereotyped as rigid, stubborn, or unyielding. Regardless of the availability of anecdotal evidence, those designations are wrong and create negative tension in the congregation.

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\[43\] McIntosh, 10.

\[44\] Grosheide, 294.
Purposeful Positioning

The church that Jesus spoke of in Matthew 16:18, “I will build My church,” was a church constructed by supernatural power and consisted of transformed people. Of this church Alva J. McClain wrote, “This points definitely to the Day of Pentecost as the historical beginning of the Church, for upon that day the Spirit of God came upon the waiting disciples to build them into one body of Christ where all distinctions of race and nation would be cancelled.”\(^{45}\) The church was historically viewed as a people, not a place or building. In Acts 15:30 Paul said, “Then, being sent off, they went down to Antioch, and after gathering the assembly, they delivered the letter.” Judas and Silas delivered the letter to the assembled church, a collection of people, in Antioch. Robert H. Gundry described Peter and future believers when he said, “Peter represents every disciple in confessing Jesus as Messiah and Son of the living God,… in belonging to the church founded on the rock of Christ’s law and helping make up that church as a stone fitted together with others to form a superstructure of obedient disciples, in facing the threat of death with the assurance of resurrection.”\(^{46}\)

In 1 Corinthians 12:18, Paul wrote, “But now God has placed the parts, each one of them, in the body just as He wanted. And if they were all the same part, where would the body be?” The church was comprised of various parts, with various gifts, and of various ages. Sometimes people excluded others who were different because of the way


\(^{46}\)Robert H. Gundry, _Matthew, A Commentary on His Literary and Theological Art_ (Grand Rapids: Eerdmans, 1982), 334.
they looked, or their background, or their age. Separation was the rule in Corinth. They created fractures in the body. What Paul was trying to teach them was that God had purposefully positioned each member of the body in the Corinthian church. None was unneeded. Each one had a purpose to fulfill. This truth was universal among the churches of God. Chafer commented, “The Lord did not leave this work to the uncertain and insufficient judgment of men. The bestowment of gifts is but another instance in which the personal and individual supervision of the exalted Christ over each member of His Body is disclosed. Each one is appointed to the exercise of a spiritual gift and that ‘as He will.’”47 Obviously, God positioned individuals within the congregation with particularly suited spiritual giftedness, and of differing ages. Diversity worked to the advantage of the congregation and for the cause of promoting the gospel. Each member deserved appreciation as distinctively different by design and purpose.

**Mutual Care**

The purposes of God are predisposed toward redemption and restoration. He obliged himself to care about man’s condition. In the church, the desire of God is for the members to demonstrate a mutual care for one another. Paul said in 1 Corinthians 12:25, “So that there would be no division in the body, but that the members would have the same concern for each other.” David Benner called this kind of care a “soul friendship.” He said, “A soul friendship is therefore a relationship to which I bring my whole self, especially my inner self. And the care that I offer for the other person in a soul friendship

is a care for his or her whole self, especially the inner self.\textsuperscript{48} In the setting of an age diverse congregation that meant that friendships developed between members of varying ages. Older members accompanied younger members on their spiritual journey. Likewise, younger members attended to the unique needs of their older mentors. That interaction pictured mutual care.

To summarize, for the mutual benefit of all the members, the church has a particular composition, or form. There exist both unity and diversity among the members. On occasion, and unfortunately, unhealthy tension and fracture occur. God purposefully positioned individual and unique members within the body to care for one another.

**The Church as Community**

**Introduction**

The body paradigm addressed the composition, or form, of the church. Function represents the other half of the equation. Form and function are inseparable. What a thing is, and what a thing is designed to do, are too closely related to disregard either. Since older adults comprise a significant portion of American congregations, they are an integral part of the community, contributing to the overall form and function of the church. How well they function within the community is a matter of importance to the life of the church.

**Calculated Service**

In Leviticus 4:13 Moses described the communal nature of seeking the Lord’s

forgiveness among the Israelites, “Now if the whole community of Israel errs, and the matter escapes the notice of the assembly, so that they violate any of the Lord’s commands and incur guilt by doing what is prohibited, then the assembly must present a young bull as a sin offering.” S. H. Kellogg commented, “Israel was taught by this law, as we are, that responsibility attaches not only to each individual person, but also to associations of individuals in their corporate character, as nations, communities, and all societies.”\(^\text{49}\)

Those who functioned as elders assumed the responsibility of implementing the sin offering ritual. In Leviticus 4:15 Moses said, “The elders of the assembly are to lay their hands on the bull’s head before the Lord and it is to be slaughtered before the Lord.” This function was critical to the community and it was carried out by revered elders. Older adults contributed greatly to the life of the nation of Israel.

James Orr, the general editor for *The International Standard Bible Encyclopedia* addressed the communal nature of the church in terms of fellowship. He said, “The fellowship at first carried with it a community of goods but afterward found expression in the fellowship of ministration and in such acts of Christian charity as are inspired by Christian faith.”\(^\text{50}\) Orr established a strong relationship between fellowship and service. Calculated service necessitates committed volunteers. Older adults have resources to contribute, especially their time. They want to live as significantly in the second half of their lives as the first. One negative stereotype of the elderly is that they stop contributing and growing. Bob Buford in *Halftime* said, “The prevailing view in our culture is that as


you close out your fortieth year or so, you enter a period of aging and decline. To pair age with growth seems to be a contradiction of terms. This is a myth I refuse to believe, and I want to help you shatter it as well. “Buford encouraged a population of recent retirees to reengage themselves in ministry. Their talents and expertise are too valuable to waste. He noted, “It is encouraging to see how some churches are becoming better at matching passion with talent.”

Pastoral care is one example of calculated service and encompasses a myriad of venues such as hospital and convalescent home visiting, homebound member ministry, and crisis care. Gary McIntosh believed that older adults, or “Builders,” were particularly suited for this ministry. He wrote, “Their past experiences probably mean they will be able to love and be willing to listen to others. Studies have found that older people find it much easier to say ‘I love you’ than young people and thus may be the best ones to extend their love through pastoral care.”

By utilizing the reserve of older adults a congregation will tap an invaluable resource. This approach benefits the older member, the congregation, and the recipient of that ministry effort. This plan is consistent with the values of a communal congregation.

Community Care

Community care is more comprehensive than the pastoral care previously mentioned. It extends to the care for that which is intangible in another person, the soul.


52 Ibid., 131.

53 McIntosh, *Taking Your Church to the Next Level: What Got You Here Won’t Get You There*, 52.
Paul described the care he received in Acts 27:3, “The next day we put in at Sidon, and Julius treated Paul kindly and allowed him to go to his friends to receive their care.” Everett Harrison in *Acts: The Expanding Church* said, “The expression, ‘his friends,’ is literally ‘the friends,’ and because of this some are inclined to understand it as a technical designation for Christians.” The care Paul received from his friends was likely physical care first, food and rest. However, they likely ministered to Paul’s soul as well with assurance of God’s protection, encouragement for his ministry, and prayers for his safety.

An unidentified biblical author referred to community care when he stated in Hebrews 13:17, “Obey your leaders and submit to them, for they keep watch over your souls as those who will give an account, so that they can do this with joy and not with grief, for that would be unprofitable for you.” Arthur Pink in *Exposition of Hebrews* said, “The true under-shepherds of Christ have no selfish aims, but rather the spiritual and eternal good of those who are entrusted to their care.” That these men were elders and pastors of the congregation was understood.

In order to further distinguish those individuals who were overseeing the faith community Pink said, “Let us also add that, young men aspiring into the ministerial office need to think twice about entering a calling which demands ceaseless self-sacrifice, unremitting toil, and a love for Christ and His people which alone will sustain amid sore discouragements.” The leaders spoken of were not novices. They were congregational elders, by position and age. The thought was furthered by 1 Peter 5:1-3, “Therefore, as a

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56 Ibid.
fellow elder and witness to the sufferings of the Messiah, and also a participant in the
glory about to be revealed, I exhort the elders among you: shepherd God’s flock among
you, not overseeing out of compulsion but freely, according to God’s will; not lording it
over those entrusted to you, but being examples to the flock.” Charles Caldwell Ryrie in
the Ryrie Study Bible said, “Elders are to feed, lead, and be an example to their people.”

Next, Peter addressed the “younger men” in verse 5. This designation differentiated
positional and aged elders from the younger men of the congregation. Community care
was a function of older men in the congregation who were spiritually adept. Frequently,
these men had a recognized designation as a congregational elder. They were not novices
in the faith, or in experience. They were examples to the community of the development
of Christian graces.

Conclusion

Older persons are of great value to the communal congregation. They offer time,
resources, and expertise to calculated service, desiring to maintain a sense of significance
throughout their lives. They are vital in community care, especially the care for the souls
of the congregation.

Healing Within the Church

In Ecclesiastes 4:9-10, the Preacher stated, “Two are better than one because they
have a good reward for their efforts. For if either falls, his companion can lift him
up; but pity the one who falls without another to lift him up.” The fallen were well-

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served by being in a relationship with a trusted companion. Inherent in the nature of relationships was reciprocity. Both benefited from the relationship. This kind of relationship was found in a solitary individual or a group of likeminded individuals. The Church of Jesus Christ is a group of likeminded individuals who have covenanted together.

Gary Collins said, “The role of the Church is that of a community of believers who are dedicated to encouraging and building up one another. In a society where there is widespread isolation, loneliness, …and broken relationships, people need the kind of community that is found only in the Church.”58 The church has the capacity to help alleviate the negative effects of loneliness in the lives of older adults. Due to the highly relational nature of the local church, meaningful friendships are a natural by product.

The New Testament outlines the obligation that Christians have to one another. The following passages demonstrate the seriousness of living collaboratively and positively regarding one another.

- Romans 12:10 - show family affection to one another
- Romans 13:8 - love one another
- Romans 15:7 - accept one another
- Galatians 5:13 - serve one another
- Galatians 6:2 - carry one another’s burdens
- Ephesians 4:32 - be kind and compassionate to one another, forgiving one another
- 1 Thessalonians 4:18 - encourage one another
- 1 Thessalonians 5:15 - pursue what is good for one another

58 Collins, The Biblical Basis of Christian Counseling for People Helpers, 204.
These passages illustrate the significant importance of living in concert with others within the faith family. Living in a loving and nurturing context has a significant therapeutic value. Henry Cloud and John Townsend in *How People Grow* commented, “Relationships provide care, support, structure, and the balm of love to heal hurts. ‘He heals the brokenhearted and binds up their wounds’ (Psalm 147:3). We know from all the commandments in the New Testament that Christ’s Body is supposed to be carrying out that work with Him.”

One of the most frequent opportunities to live restoratively presents in the form of comforting those who are grieving. Cloud and Townsend said, “Grief is God’s way of getting us through and past things. And we need others to help us do that. Therefore, the Bible says to ‘mourn with those who mourn’ (Romans 12:15). If we do that, we find the reality of what Jesus said: ‘Blessed are those who mourn, for they will be comforted’ (Romans 5:4).” Comfort comes from God, sometimes through His Spirit and other times through His people. Albert Barnes in *Notes on the New Testament – Romans* said of Romans 12:15, “The design of this direction is to produce mutual kindness and affection, and to divide our sorrows by the sympathies of friends. Nothing is so well fitted to do this as the sympathy of those we love.”

Barnes gave four reasons for engaging in suffering with fellow Christians. The first reason was because Jesus set the example for suffering by giving himself

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60 Ibid.

sacrificially. Secondly, Christians join in suffering with others because they are all part of the same family of faith. The third reason was because all are subject to the same kind of suffering and affliction. Suffering is part of the human experience. The fourth and final reason was because if Christians do not mourn and suffer along with each other they will go uncomforted. They cannot expect the world to offer them comfort.

John Murray in Epistle to the Romans addressed the two halves of Romans 12:15. First he discussed the admonition to “rejoice with those who rejoice.” Murray said, “The point of the exhortation is that we are to enter into this rejoicing as if the occasion for it were our own. If we love our neighbor as ourselves, if we appreciate the community within the body of Christ, the joys of others will be ours.” He further pointed out that celebration was a foreign concept to those who had not been redeemed by Christ. One naturally fails to rejoice for something that has no possible benefit. Rejoicing for others signifies loving others, and demonstrates the transforming power of God, especially when one rejoices with his brother over something fortuitous in his life.

Next, Murray addressed the latter half of Romans 12:15, “weep with those who weep.” He said, “Identification of ourselves with the lot of others is here again commended. Weeping means sorrow, pain, and grief of heart. Weeping is unpleasant; no one invites grief. But our love for others will constrain in us the sorrow of heart which the providence of God metes out to our brethren in Christ.” Again, Murray saw the execution of voluntarily weeping with others as being an unnatural action apart from the

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63 Ibid.
grace of God in the life of the believer, and a supernatural action wrought in those who have crucified themselves, taken up their cross, and are following Jesus.

Dallas Willard in *The Spirit of the Disciplines* commented on the greatness of the apostle Paul when he wrote, “He knew the Master’s secret that the greatest person is the one who is servant of all, and he put it into practice as a matter of principle. His whole life was to be the servant of all, just like Jesus, and that is why such great work was trusted to him and not to others.” Willard saw true significance in service to others. In this context loneliness in an individual was combated by the faithful love and service of others. Mutuality in the body aided in healing those wounded by life.

When John MacArthur spoke of Jesus’ utilization of the disciples, he noted that “there was no plan B if they failed.” Various congregations may or may not effectively attend to the emotional needs of their membership. Yet, when individual members are ministered to and nurtured, the entire congregation is made stronger. David Augsburger noted that the church must “look for opportunities of affirming and encouraging, of helping release others to be all they can be in Christ. Concern for mutual fulfillment, joint opportunities for service and shared meaningful work is the real goal.”

That he suggested assisting a weaker, more vulnerable individual is clear. Older adults who are lonely, isolated, afraid, and depressed particularly need the help of a loving church community. Gary Collins said, “Get the congregation in contact with the

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elderly and involved in helping; plan programs for seniors, create opportunities for older people to get involved in useful service.” 67 Again, this admonition is seen as both a responsibility and an opportunity. When congregations appropriately love their older members the whole body becomes healthier.

When the older adult who feels depressed due to loneliness engages in a self-imposed isolation he or she may encounter difficulty reconnecting with society in general. The world may seem too big or frightening. He or she may have a sense of not belonging anywhere. However, Collins wrote, “The Church is the place where older adult Christians already belong. They can reconnect with a community.” 68 Focusing on the fellowship of the local assembly of believers helps the lonely person to forego less appropriate or unsatisfying venues to assuage his or her loneliness. By reconnecting with the local church, the older adult may find that the longings of his or her heart are met.

In Inside Out, Larry Crabb called these longings “critical longings.” 69 These longings are met through high quality relationships with friends who will be available when needed.

In summary, Christian companions help to make life livable. A major theme of the church of Jesus Christ is to “love one another.” Older adults who suffer from depression due to the effects of loneliness comprise a segment of many congregations. The entire congregation becomes stronger as lonely older adults are loved, encouraged, and nurtured to a place of renewed ministry.


68Ibid., 198.

Introduction to General Literature Review

Change may appear to accelerate in old age. Life altering events can happen rapidly, potentially leaving the older adult at a loss for effective mechanisms for coping. For instance, of the 900,000 adults who lived in assisted living facilities in 2006, 75 percent were females and their average age was eighty-six. Over 60 percent of those women had previously lived in their own home. Their lives changed dramatically. This section explores a profile of older adults, the problem of depression caused by loneliness, and a potential aid in combating loneliness in an older adult population.

The project director issues a disclaimer regarding the total body of work contributed by certain individuals referenced in the general literature review. Although generally recognized for making significant contributions to the field of psychology, education, or gerontology, issue may be taken with the philosophical foundations or the logical and ultimate outcomes of their arguments. No endorsement extends past the particular parameters of the project.

A Profile of Older Americans: 2011

The United States Department of Human Services, Administration on Aging collects and compiles information on older Americans each year. The following statistics give an accurate picture of aging in America:

- The older population (sixty-five years of age or older) numbered 40.4 million in 2010.
- Over one in every eight, or 13.1 percent, of the population is an older American.

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• Persons reaching age sixty-five have an average life expectancy of an additional 18.8 years.

• About 29.3 percent of noninstitutionalized older persons live alone.

• Half of older women (47 percent) age seventy-five and older live alone.

• The population sixty-five years old and over will increase to 55 million by 2020.

• The eighty-five years of age or older population is projected to increase from 5.5 million in 2010 to 6.6 million in 2020.

• The median income of older persons in 2010 was 25,704 dollars for males and 15,072 dollars for females.

• Social Security constituted 90 percent or more of the income received by 35 percent of all Social Security beneficiaries.

About 3.5 million elderly persons (9 percent) were below the poverty level in 2010.71

These statistics paint a picture that looks dramatically different from generations past. America has entered a period when there are more older adults than at any point in history. They have changed the demographics of the country and the way old age is viewed. As older Americans live longer and healthier lives, many are planning to work longer than their counterparts in previous generations. According to a recent survey, 80 percent of baby boomers expect to work past traditional retirement age.72 Some may do so because they enjoy physical and mental benefits, while some may need the additional income to remain financially secure. Regardless of the reasons for staying at their jobs, older adults are changing the way the nation views retirement. No longer does a one-size-fits-all way of looking at retirement seem appropriate.


Older Adult Lifespan Issues and Challenges

Introduction

Each developmental phase of life presents challenges. Simply because one has been relatively successful in negotiating previous life phases does not guarantee success in the next. Each stage bears its own peculiar tests of the adaptability, durability, and often times the sheer will of the individual. The American Psychiatric Association in the *Desk Reference to the Diagnostic Criteria from DSM-IV* listed V62.89 Phase of Life Problems among, “Other Conditions That May Be a Focus of Clinical Attention.”\(^73\) Phase of Life Problems are explained as - “a problem associated with a particular developmental phase or some other life circumstance that is not due to a mental disorder. Examples include problems associated with entering school, leaving parental control, starting a new career, and changes involved in marriage, divorce, and retirement.”\(^74\)

A representative issue from almost every life stage is listed. Even when there is an assumption of maturity and advanced age, such as in retirement, the possibility for difficulty to the point of the need for therapeutic intervention is present. Persons are never immune to the complexities of life. Guy Lefrancois in *The Lifespan* quoted Lewis Carroll’s *Alice in Wonderland* when he wrote, “‘Begin at the beginning,’ the King said gravely, ‘and go on till you come to the end: then stop.’”\(^75\) Life rarely presents so uncomplicated.

\(^{73}\) American Psychiatric Association, 301.

\(^{74}\) Ibid.

In beginning to look at lifespan issues one must first consider the context. Life happens in context, and that context may significantly influence outcomes. Salvador Minuchin in *Families and Family Therapy* illustrated this point when he quoted the following parable: “Peary relates that on his polar trip he traveled one whole day toward the north, making his sleigh dogs run briskly. At night he checked his bearings to determine his latitude and noticed with great surprise that he was much further south than in the morning. He had been toiling all day toward the north on an immense iceberg drawn southwards by an ocean current.” The outcome had been greatly manipulated by the context.

The lifespan of an older adult must be seen as existing in a context, and that context except for unusual circumstances involves relationships with others. Systems ensue from these entwined networks of relationships. Individuals are born into families and family systems. Mistakenly, some have tried to look at lifespan issues on an individual basis. Exploring the issues as part of a system that influences outcomes provides a more accurate picture. Murray Bowen in *Family Therapy in Clinical Practice* said, “A systems view of man represents a different order of thinking than is represented in our conventional theories. It is difficult for a man to shift from conventional toward systems thinking. I am not sure he can ever shift to systems thinking, when he is thinking about himself.” Older adults do not live in a vacuum. They have interacted within a

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system over the lifespan. Much of the difficulty of being elderly is related to the 
modification of the family system. When Bowen explained his early work in family 
systems he described studying “the family as the unit of illness.” This depiction 
accurately includes both the individual who had presented with pathological tendencies 
and the system in which he or she operated, and which significantly influenced behavior. 

Those currently classified as elderly have most likely experienced the classical 
extended family. Richard Clayton in *The Family, Marriage, and Social Change* described 
this family system when he wrote, “In the classical extended family running through the 
maleside, an extended family is one with three or more generations living in one house-
hold, or within one compound, with the grandfather actively serving as the family head, 
and with married sons and their families, as well as unmarried sons and daughters.” The 
Walton television family depicted the classical extended family which was designed for 
primary relationships, and are ideal nurturing places. When one grows up in the classical 
extended family it becomes the family schema from which all other systems are 
evaluated. The idyllic system becomes problematic as the system ages and changes. The 
new looking and functioning system is difficult for the older adult to embrace. Frequently 
the new system is classified as inferior simply due to differences from his or her family of 
origin system. 

Challenges of old age often develop from contextual changes beginning at

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78 Ibid.

midlife. Carol Anderson described views of midlife and beyond when she wrote,

At midlife, forgotten dreams and age-old passions return to haunt us all. These visits from the past, along with an increased awareness of the passage of time and a host of current life-cycle events and changes, such as career plateaus, empty nests, loss of family and friends through death and illness, and decreased physical well-being, have led many to believe that midlife is inevitably a time of crisis for individuals, with a resultant disruptive impact on marital and family relationships.⁸⁰

Although this does not depict everyone’s midlife experience, it does illustrate the reality encountered by many. Changing circumstances and a changing system may be upsetting to the point that an individual may enter a state of crisis. Retirement may be viewed as both a loss of financial resources and a loss of a sense of significance. Declining physical and mental acuity and increasing health complications present hardships and challenges. All older adults ultimately encounter adverse circumstances. Their family system will be altered by death, theirs or the death of those around them.

Retirement Issues

Retirement has become a reality for an increasing number of older adults. Lefrancois described it as “a 20th-century phenomenon, a sort of luxury made possible by a rapidly increasing standard of living, extraordinarily high productivity, and a relatively large surplus of labor.”⁸¹ Some occupations demand physical vitality and therefore may have a form of forced retirement. This assertion is true in an agrarian society and extends to construction, the factory, and heavy manufacturing. Worker perspectives of forced retirement are considerably more pessimistic than for those engaging in planned

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⁸¹Lefrancois, 618.
retirement. Additionally, forced retirement workers are more likely to be financially unprepared for a long retirement. Workers who earn more and whose educational backgrounds are higher view retirement more positively.

Daniel Levinson in *The Seasons of a Man’s Life* depicted retirement almost as a duty when he said, “But, even when a man has a high level of energy and skill, he is ill-advised to retain power well into late adulthood. He tends to be an isolated leader, in poor touch with his followers and overly idealized or hated by them. The continuity of the generations is disrupted.”82 Levinson saw this period in an aging man’s life as an opportunity to step aside and allow younger leaders to emerge, taking their rightful place. This philosophy was not necessarily shared by workers just a few years ago. Leslie Morgan and Suzanne Kunkel in *Aging, Society, and the Life Course* said, “The idea of retirement had to contend with a strong work ethic that suggested that the worth of an individual was tied to her or his productivity, most specifically in the labor force.”83 That outlook has changed considerably over the past fifty years. Retirement is viewed more positively in general as something that people have earned. Societal changes in regard to the pursuit of leisure activities have helped to reformulate the view of retirement. R. C. Atchley believed that successful retirement is likely when four sets of circumstances are met: retirement must be voluntary, the most important thing is not a person’s work, health and income are sufficient to enjoy activity, and the retirement has been well planned.84

Problems arise when retirement is ill planned and is viewed unrealistically.

84Lefrancois, 620.
Reasonably, when one retires there must be sufficient financial resources to accommodate the desired lifestyle of the family system or everyone in the system suffers stress. A more difficult aspect of retirement to prepare for is the change of one’s status and sense of significance after retirement. Vince Napoli in *Adjustment and Growth in a Changing World* remarked, “They often lose their sense of purpose and their self-esteem suffers.”

Emotionally healthy individuals want to have a sense of significance, to believe that they are contributing to society and that their life matters. Long periods of inactivity and a lack of productivity can contribute to the devaluation of one’s sense of self. Valerian Derlega and Louis Janda in *Personal Adjustment – The Psychology of Everyday Life* called this phenomenon a matter of self-concept and wrote, “Self-concept is somewhat broader (than self-esteem) and includes the many ways in which people can view themselves. All of us play a number of roles in life. Our self-concept involves how we view ourselves in relation to these roles.”

Retirees have so significantly altered their lives that they may feel that they have actually abandoned their role or purpose for living. The phenomenon occurs when one too strongly correlates worth with work. Levinson added, “A primary developmental task of late adulthood is to find a new balance of involvement with society and with the self.” Finding this new balance may prove to be difficult and become one of the challenges of old age. When one does not adjust well to the new retirement system the

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87 Levinson et al., 36.
family system is adversely impacted. The retiree may become depressed, angry, or lethargic. A typical response is a demonstration of periods of high energy and a flurry of activity followed by periods of inactivity and under-functioning. These swings in mood and activity stress the family system, causing others within the system to attempt to compensate for the person in distress. Eventually the pathology causes a systemic crisis.

Death Anxiety and Bereavement

Death is the common denominator, the universal experience. Impending death and the attending issues are among the most stress producing considerations among older adults. Robert Kastenbaum in *Death, Society, and Human Experience* said, “It is not easy to approach death. Like our fellow creatures on earth, we are inclined to head in the other direction when we come across a threat or harbinger of death. We might feel like avoiding the topic of death even while we are approaching it. We can admit our ambivalence without apology. The business of life is to stay alive.”

Older adults are faced with the reality of death, whether imminent or distant, because death is more in view than at any other point in their lives. Issues surrounding death, whether one’s own death or the death of a spouse or close friend, are highly personal and wrought with emotion. Even the most emotionally healthy persons may have difficulty accepting their ultimate mortality.

Kastenbaum defined a particular kind of anxiety associated with death when he noted, “Death anxiety is emotional distress and insecurity aroused by encounters with dead bodies, grieving people, or other reminders of mortality including one’s own

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thoughts.”\textsuperscript{89} A safe assumption is that most people experience some degree of distress and insecurity when faced with impending death. The concern may be for themselves or for their loved ones who comprise their family system. Death preparation frequently involves complicated matters, and at a time of physical or mental frailty, the situation may be quite stress producing. On the course and trends in death anxiety, Kastenbaum commented, “Death anxiety tends to be relatively high in adolescence and early adulthood, decreasing as life becomes more settled and predictable. Death anxiety is likely to rise again in later middle age, perhaps occasioned by the death of friends and family along with signs of one’s own aging. After this rise, there is a decline to a new low in death anxiety for people in their seventies.”\textsuperscript{90}

When rational persons feel threatened they naturally defend against the perceived threat. Josh Gerow in \textit{Psychology – An Introduction} defined a defense mechanism as, “unconsciously applied techniques that protect the self (ego) against strong feelings of anxiety.”\textsuperscript{91} Reasonableness suggests that persons facing death, theirs or the death of a spouse, would develop an emotional defense mechanism in order to feel less vulnerable. Some employ the use of denial. Denial is associated with death anxiety. Kastenbaum defines denial saying, “Denial rejects the existence of threat.”\textsuperscript{92} Even though denial is not entirely rational it may give the person employing it the time to process the information and prepare to deal realistically with the situation. However, denial is usually a short

\textsuperscript{89}Ibid., 22.

\textsuperscript{90}Ibid., 18.

\textsuperscript{91}Josh R. Gerow, \textit{Psychology: An Introduction}, 5\textsuperscript{th} ed. (New York: Addison-Wesley Educational Publishers Inc., 1997), 327.

\textsuperscript{92}Kastenbaum, 19.
lived mechanism. Denial in the case of death cannot be embraced for very long by rational people. Instead, denial must give way to realistic and effective methods of coping. Older persons are not prone to linger in denying what is clearly evident.

Bereavement is closely associated with the mature adult experience. For one to outlive a spouse, other family, or friends is common. Except for unusual circumstances, married persons will eventually come to the place where one dies and leaves the other. Bereavement is inevitable. Robert Baron in *Psychology* said, “Bereavement is the process of grieving for the persons we love who die.”

He further explained how bereavement presents as he commented:

> The research suggests that bereavement is a process in which individuals move through a series of discrete stages. The first is shock – a feeling of numbness and unreality. This is followed by stages of protest and yearning, in which bereaved persons resent the loss of their loved one and fantasize about the loved one’s return. These reactions are often followed by deep despair, which can last a year or more – a period when bereaved persons feel that life is not worth living. Finally, bereaved persons usually enter a state of detachment and recovery, in which they separate themselves psychologically from the loved person who has died and go on with their lives.

Mourning is the overt expression of bereavement and is descriptive of the outcome or result of bereavement. When one is bereaved, one mourns. Alan Wolfelt in *Death and Grief – A Guide for Clergy* said, “The specific ways in which people mourn are influenced by the customs of their culture. The mourning behavior exhibited may or may not be in agreement with true feelings of the bereaved; however, they may incur

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94 Ibid., 376.
This understanding of mourning brings into view the concept of context and systems. Older persons are subject to pressures from their systems. Even in something so personal as bereavement and mourning, there may be pressure to behave in a way not in concert with one’s own personality.

Conclusion

Many issues facing older adults cause concern and present intense personal challenges. Among them are issues revolving around retirement. Both the issues of potentially diminished finances and a sense of diminished self-worth are frequently associated with retirement. Death anxiety, bereavement, and mourning are common experiences for older adults. Older persons are in a position closer to these realities than ever before. The aged have a front row view of coming attractions that may prove quite disconcerting. The elderly person navigates these issues in the context of a system. Mature adults are personally challenged and coping systems are significantly stressed.

Depression in Older Adults

What an individual does is frequently dictated by what he or she thinks that others expect. Societal forces shape lives to some extent. This reality is true of some of the negative aspects of aging. Social policies and practices as well as societal expectations and norms shape how older adults live out their lives. Learned helplessness is one such negative aspect of aging that has roots in social practices. When government policy

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makes people dependent, it often leads to their disengagement with society at large. Dependency and disengagement frequently facilitate depression in older adults.\textsuperscript{96} Depressed mood associated with isolation is a significant factor in health issues among older adults. Depression is generally a powerful “predictor of poor health.”\textsuperscript{97}

Social policy and societal expectation are not the only factors contributing to depression among this population. Many life-altering events such as the death of a spouse, declining mobility, and infrequent contact with family result in significant bouts of depression.\textsuperscript{98} These events are closely associated with loneliness which breeds both illness and early death. Among people whose relationships with others are fewer and weaker, “the risk of death is two to four times as great,” irrespective of any other personal factor.\textsuperscript{99}

The American Psychiatric Association classifies depression as a mood disorder. Of the several varieties of depression, older adults may most often present with Dysthymic Disorder. The primary difference between Major Depressive Disorder and Dysthymic Disorder is the latter tends to be a chronic condition and generally less severe than the former. Diagnostic markers for Dysthymic Disorder are “poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness. Symptoms cause clinically significant distress or impairment in social, occupational, or other


\textsuperscript{99}Ibid., 156.
important areas of functioning.”

A primary contributing factor to depression among older adults is loneliness. Persons are often more isolated during advanced old age. W. Leslie Carter, Paul Meier, and Frank Minirth discussed a kinship between loneliness and associated emotional and psychological disorders including “feeling out of fellowship with God, constant guilt feelings, low self-esteem, exaggerated feelings of dependency, harsh or critical feelings, living according to absolutes, anger, depression, a sense of rejection, anxiety, confusion, and disillusionment.” They suggested that becoming active again and being intentional about being around other people will help significantly to combat feelings of loneliness.

James Coleman in *Abnormal Psychology and Modern Life* discussed the causes for old-age psychoses. Among the contributing factors, he listed isolation and loneliness as a major cause of depression among this older population. He said, “As the individual grows older, he is faced with the inevitable loss of loved ones, friends, and contemporaries. The death of one’s mate, with whom he may have shared many years of close companionship, is often a particularly difficult adjustment problem. This is especially true for women, who tend to outlive their spouses by some seven years.” Coleman considered these sociological factors foundational to older adults developing psychological dysfunction. Unfortunately, these factors are inherent in the lifestyles of many older adults.

Loneliness and isolation commonly occur following the death of a spouse. Since

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100American Psychiatric Association, 170-71.

101Carter, Meier, and Minirth, 91-116.

the death trajectory is different for each individual, sometimes sudden and other times lingering, psychological outcomes vary accordingly. Survivors of those who die suddenly frequently have a greater difficulty in reconciling the loss of the loved one. Positively, they are not subjected to a lingering trajectory with the significant stress associated with a protracted fatal disease. Betty Carter and Monica McGoldrick in *The Changing Family Lifecycle* identified this stress as being detrimental to adjustment after the loved one has died. They said, “Families in which a member has a long illness such as cancer suffer from the stresses of permanent uncertainty. They are never sure of the course of the illness. This constant uncertainty can wear the family out emotionally.”

When individuals are subjected to long periods of stress they more easily fall prey to psychological and physical collapse. Prolonged stress contributes heavily to the onset of depression in the surviving spouse, especially the older adult survivor.

About 15 percent of older people in the community and 25 percent of nursing home residents suffer from depression. Among all of the possible contributing factors to this rate, having functional limitations in physical health is the strongest predictor of major depression. The odds of becoming depressed are twice as great among older adults who are experiencing moderate physical limitations. Sometimes issues of physical decline outweigh, and contribute to, physical limitation and cause depression. Having to sell a house to pay for hospital expenses can produce psychological trauma in

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104 Morgan and Kunkel, 257.

105 Ibid., 258.
elderly persons. Individuals may become depressed due to the belief that he or she simply have no legitimate choices. He or she may feel that life is irrevocably out of control. The physically frail are particularly vulnerable to feelings of loneliness because they often spend long periods of time alone. With no particular reason to go out of their homes, they tend to become increasingly isolated. Isolation, whether self imposed or due to inability to be mobile, is a common theme among older adults. In one recent study as many as 75 percent of the sample group had fewer than twenty-one direct, face-to-face contacts a week qualifying as “socially isolated.”

The Alliance for Aging Research published these facts about depression among older adults:

- Depression is a chronic disease with a very high likelihood of recurrence.
- Six million elderly suffer from some sort of depression.
- Clinical depression can often accompany long-term illnesses.
- The number of suicides each year is greater than the number of deaths from homicide.
- In the elderly population, men are nearly six times more likely than women to commit suicide.

106Derlega and Janda, 157.
107Baron, 551.


109Ibid.
• Less severe forms of depression are also common among the elderly and can be as debilitating as Major Depressive Disorder.\(^\text{110}\)

Often times depression goes undetected among the older adult population.\(^\text{111}\) Because contact is reduced with the outside world and with families who know them well, the problem is never addressed. Even when in contact with a primary care physician, studies show that less than one-half of depressed elderly are ever diagnosed.\(^\text{112}\) Some speculate that primary care physicians are not trained to look for symptoms in their older patients. Another factor that may contribute to low rates of diagnosis and treatment of depression among this population is “the pervasive myth that depression is a normal part of aging.”\(^\text{113}\) According to Lea Ann Browning McNee, senior vice president of public affairs and community development at the National Mental Health Association, “no one has to live with depression.”\(^\text{114}\)

Unfortunately, the elderly are more likely to try to deal with depression alone rather than consult a mental health professional. This “aloneness often breeds loneliness,” further contributing to the problem.\(^\text{115}\) Myers has charted that lifecycle and explained, “We can now assemble the pieces of the depression puzzle: (1) stressful events interpreted through (2) a ruminating, pessimistic explanatory style create (3) a


\(^{111}\)Alliance for Aging Research, “Detecting Depression Before It’s Too Late,” http://www.agingresearch.org/content/article/detail/854/ (accessed November 10, 2009).

\(^{112}\)Ibid.

\(^{113}\)Ibid.

\(^{114}\)Ibid.

\(^{115}\)David G. Myers, Psychology (New York: Worth, 1998), 475.
hopeless, depressed state that (4) hampers the way the person thinks and acts. This in turn, fuels (5) more negative experiences. “This lifecycle is self-perpetuated and self-defeating. With the cyclical nature of depression in view, some form of intervention on the part of the older person caught in the cycle must be employed. A viable strategy involves greater socialization and therapeutic interventions.

To summarize, sometimes societal forces shape negative practices among older adults leading to depression. Life altering events contribute heavily to negative change in the lives of older adults. Functional limitations in the physical condition of older adults are the most profound cause of their depression. Frequently depression goes undiagnosed in the elderly population due to lack of awareness of primary care physicians. Perhaps depression is undiagnosed because of the myth that depression is normal among this population of older adults.

The Benefits of Socialization

Agencies who work with the elderly realize that isolation and loneliness are problematic. Families must encourage their loved ones to “share their concerns, with a health care professional, faith leader, or other resource person.” The problem must be addressed within the context of community by people who represent various facets of the older person’s life. The problem of isolation cannot be treated in isolation. In fact, “social support has a direct positive effect on health. It can buffer or reduce some of the health related effects of aging.” One does not outgrow the need for others. The “life-

116Ibid., 174.

117Alliance for Aging Research, “Detecting Depression Before It’s Too Late.”

118Rowe and Kahn, 153.
giving effect of close social relations holds throughout the life course.”

One study of elderly patients hospitalized with major depression disorder revealed that “long term marriages are viewed as positive.” Patients recovered more quickly and were released from the hospitals earlier than their unmarried counterparts. When an individual has no spouse to return home to, one must have “close friendships or confidants.” Confidants prove to be extremely important in maintaining high morale which is closely associated with a general state of happiness. A study published by Age and Ageing looked at the persistence of depression in older people. It concluded that a “belief in powerful others” had a positive effect in recovery and that “a low belief in powerful others predicted depression persistence.” Having a support network proved to be a significant factor in their recovery. Similarly, a study of individuals over one hundred years of age showed that “the most well preserved people are those who remain intellectually stimulated, those who still maintain satisfactory social relationships and, in particular, can count on the help of the family or others.”

When asked to identify strategies to help combat loneliness and depression, older people themselves suggested

\[\text{Ibid.}, 156.\]


\[\text{Lafrancois, 635.}\]


that the best intervention was an “enhanced social network promoting a sense of neighborliness and community.”

Maintaining “satisfactory social relationships” has even been recognized as a predictor of long life.

Participation in religious faith, as a particular form of socialization, is seen as important to some of the most elderly. Those interviewed found “greater solace in faith than less elderly groups.” Many believe that religious involvement is a contributing factor to the longevity among this population. Religious practices play a significant role in the lives of older Americans “where approximately one-half of the older population attends religious services at least weekly.” Statistics suggest a strong positive correlation between longevity and religious involvement and practice. This finding makes the “neglect of religion and spirituality by gerontologists all the more surprising.” The statistics, although not having made an impact on gerontologists at large, have not gone unnoticed by everyone.

As reported by the Centers for Disease Control and Prevention, the City of Seattle’s Aging and Disability Services and Senior Services of Seattle are cosponsors of the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS). The program

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\[ ^{124} \text{Victor, Bowling, Bond, and Scamber, “Loneliness, Social Isolation and Living Alone in Later Life.”} \]

\[ ^{125} \text{Buono, Urciuoli, and De Leo, 212.} \]

\[ ^{126} \text{Ibid.} \]


\[ ^{128} \text{Ibid.} \]
“aims to reduce minor depression and resulting disability among older adults by teaching them depression management techniques.”\textsuperscript{129} This public program will encourage participants to “meet recommended levels of social and physical activity by using community settings, such as senior centers, community centers, and faith communities.”\textsuperscript{130} Similarly, the United States National Institutes of Health, National Institute on Aging Council Minutes from May 1996 reveal federal funding for the Behavioral and Social Research Program. A significant part of the research will be conducted in the area of “health and religion.”\textsuperscript{131}

In summary, the problems of loneliness and depression among the elderly population are best addressed in a multidisciplinary social context. Hospitalized patients who have a strong social network, or at least one confidant, recovered more quickly than their counterparts who were alone. A strong positive correlation exists between health and religious practice. The government, on multiple levels, is involved in studying the relationship between health and religion.

**Therapeutic Interventions**

**Introduction**

Old age is not preventable but is treatable. Some of the unpleasant issues inherently associated with old age may be delayed for a while, but ultimately nature


\textsuperscript{130}Ibid.

triumphs and the body and mind succumb to certain frailties. Challenges such as diminished physical ability, loss of cognitive acuity, perceived lower social value, disengagement, loss of relationships through death, and bereavement and grief must eventually be acknowledged and addressed. How these issues are attended to vary greatly and depend on four primary factors: the model utilized to contextualize and address the problem, the attitude and ability of the elderly person, the theoretical perspective of the one who is providing therapeutic services, and the context in which all these occur.

Model of Care

The primary model of care for elderly persons has historically been the medical model and the propagation of that model, medicalization. Morgan and Kunkel defined medicalization as “the process of legitimating medical control over an area of life, typically by asserting the primacy of a medical interpretation of that area.”\(^\text{132}\) Although seeing the wisdom and necessity of providing medical care, they do not advocate this model alone in helping older persons. They address the premise of the medical model saying, “One outcome of this view is a focus on disease as a physical process, with little attention to the complex interplay between the physical and the social, emotional, and spiritual aspects of existence. ‘Reductionism,’ which is based on mind-body dualism, is the tendency to reduce any illness to a disorder of the physiological system of the body of the affected individual.”\(^\text{133}\) While this way of viewing the person does look for the cause of a particular disease, it does not explore the context of that person as existing and interacting within a system that has a bearing on the specific outcome. Context cannot be

\(^{132}\)Morgan and Kunkel, 271.

\(^{133}\)Ibid., 270-271.
ignored if one hopes to effect significant change in the life of an elderly person.

Moody believed that the medical model utilizes a restricted view of the problems of old age, and wrote, “This model of life and health, while useful, has obscured a larger perspective.”134 He suggests that the premises of the medical model are: “The human life span is increasing. Death is the result of disease. Disease is best treated by medication. Aging is controlled by the brain and the genes.”135 This model purports a basic cause and effect scenario. It reduces the condition of the elderly person to a disease model alone, overlooking environmental and sociological factors. Further, it ignores the immediate context of the family system. These factors are too influential in the lives of the elderly to be discounted.

A different approach would better serve older adults. Morgan and Kunkel suggested a new paradigm and model of care for the elderly. The paradigm assumes a significantly more holistic approach and is seen as multidisciplinary. They explained, “Geriatric medicine is distinguished by specialized training in conditions that affect older people; a holistic approach to understanding the interactions among aging, disease, mental health, and independence; and a focus on coordinated interdisciplinary care that involves families and other caregivers important in the lives of older patients.”136 This approach may be viewed as superior to a pure medical model due to a broader scope.

Attitude and Ability of the Elderly

Attitude influences outcome. For example, depressed individuals make decisions

134 Moody, 44.
135 Ibid.
136 Morgan and Kunkel, 274.
differently from people who are not depressed. Moody said, “Depressed patients are more likely to refuse procedures in situations where the medical prognosis is actually good. The factor that explains most of the differences may not be clinical depression, but broader quality of life, which a diagnosis of clinical depression may not capture.” The medical model does not allow for the exploration of the depressed elderly person’s context, his family system, or his general satisfaction with life. While these issues are not easily and quickly discerned, they have great bearing on the etiology of the depression. Additionally, by understanding circumstances, one may have a greater opportunity to help the older adult. When direct physiological reasons for the depression are absent, other psychosocial factors are involved. When these factors have adversely affected the elderly person, his depressed state of mind negatively influence and limit his ability to participate in treatment.

Mutual participation between the counselor and the client is preferable in the counseling process. In the case of the moderately depressed person engagement may be difficult. The collaborative process that enables the participants to work as a team is thwarted by the inability of the client to engage, discern, and plan. The client is not able to participate fully in developing a plan to solve the particular problem. This person necessitates a directive counselor. Richard James in Crisis Intervention Strategies said, “The crisis worker is the principal definer of the problem, searcher for alternatives, and developer of an adequate plan, and instructs, leads, or guides the client in the action.” The effective counselor will help the client to engage and participate in his treatment as

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137 Moody, 391.

soon as possible. The goal is a collaborative effort. The client must take ownership of his situation and ultimately take responsibility for therapeutic outcomes.

On the other hand, the older adult may be functioning fairly well and present with the ability to think clearly and rationally. Therapeutic intervention is sometimes more about support and encouragement and has to be far less directive. In those cases James suggested, “The worker is a support person who may listen, encourage, reflect, reinforce, self-disclose, and suggest. Nondirective counseling assists clients in mobilizing what is already inside them – the capacity, ability, and coping strength to solve their own problems in ways that are pretty well known to them already but that are temporarily out of reach.”139 Whether or not a counselor can function as a support person is determined by the attitude and ability of the client. Some older people will be able to participate more fully. The intervention should always be consistent with the ability of the older adult to participate. Never should the elderly be demeaned in the therapeutic process. Treating them as incapable of participating assaults their dignity. When the counselor functions as an encourager the elderly person feels less dependent, more empowered, and is self-directed in the therapeutic process.

Theoretical Perspective of the Helper

The theoretical perspective of the helper is of critical importance in the helping process. Most physicians will have adopted the medical model for treating all of their patients regardless of age, circumstance, and sociological differences. Their theoretical perspective will follow this schema, and they will utilize medicines to promote health as

139Ibid., 66.
they define health. This approach may prove unhelpful in understanding the older adult and prove insufficient in promoting change.

Counselor prejudices regarding aging individuals changes the outlook for the probability of success in treatment. Ageism is a form of discrimination that is widely accepted in subtle forms. When older adults become the brunt of jokes and puns, they are diminished as individuals of worth. When individuals are devalued, treatment may be seen as a hopeless cause. Some therapists may have a negative predisposition toward older people. Gerald Corey, Marianne Corey, and Patrick Callanan in *Issues and Ethics in the Helping Professions* said, “Developing a counseling stance is more complicated than merely accepting the tenets of a given theory. We believe that the theoretical approach you use to guide your practice is an expression of your uniqueness as a person and an outgrowth of your life experience.”

They postulate the significance of the relationship between the counselor’s personal biases and experiences and the type of help they offer. Who treats the older person and the choice of interventions employed have a strong correlation on the probability of a successful outcome. Theoretical perspective determines when, why, what, and how treatment will be delivered.

Being positive toward the older person is helpful to the therapeutic process. Cynthia Poindexter, Deborah Valentine, and Patricia Conway in *Essential Skills for Human Services* said,

Help giving will be more effective if helpers assume a positive stance toward others. Instead of focusing on weaknesses, focus on strengths. Instead of trying to

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catch people doing something wrong, strive to catch them doing something right. Helpers who assume that others have capacity to manage events in their lives and build upon resources and strengths are more effective than helpers who label individuals, couples, and families ‘deficient,’ ‘sick,’ or in need of our correction.  

That positive attitudes are correlated with positive outcomes is not surprising. Some therapists may be reluctant to admit their prejudices or find it difficult to suspend their judgment. This counselor should be ethical enough to refer the older client with whom he has no good therapeutic relationship. A positive relationship provides a basis for work to be productive.

Some elements are common among all the psychotherapies and their attending theories and methodology. Such factors are important to the likelihood of success for the client. Stanton Jones and Richard Butman in *Modern Psychotherapies* said, “The common techniques that all psychotherapists seem to use include: (1) offering reassurance and support, (2) desensitizing the client to distress, (3) encouraging adaptive functioning and (4) offering understanding and insight.” These qualities demonstrate positive regard for the older person and encourage the goodness of fit necessary for a good therapeutic relationship. They are recognized generally among the helping profession as a minimum standard for adequate care.

In a similar context, James Prochaska and John Norcross in *Systems of Psychotherapy* identified, “support, interpretation, insight, behavior change, a good therapeutic relationship, and certain therapist characteristics” as common features

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of a successful experience for the client. These factors are not extraordinary expectations. They are good standards of practice for human services workers in general. Clients should be able to anticipate these characteristics at minimum.

Context

Context is not to be understood as a place but a situation or circumstance surrounding an individual. In the context of this project, older adults who were grieving, lonely, and depressed were in view. All helping takes place in context. Context is as distinct as the differences among the various cultures in a pluralistic society. John Axelson in *Counseling and Development in a Multicultural Society* said,

Relatively few counselors have been specifically trained to understand and work with the problems of aging and the aged within the context of a multicultural society. Working against inaccurate stereotypes that prevail for both the elderly in general and the elderly within identified cultural groups is a major task for the professional counselor. Furthermore, it is important for counselors to approach elderly persons with the view that they may be socially integrated and adjusted within the context of their own cultural value system and expectations.  

Understanding the uniqueness of the context is necessary to properly assess the needs of the client. Diagnostics are invalid and treatment plans inadequate if the context has been ignored or misconstrued. Although some common characteristics are evident among all older adults, more qualities are peculiar to the specific individual in need of services. In the case of providing therapeutic services, one size does not fit all.

Effective therapists understand their client’s perspective. Albert Ellis in *Reason and Emotion in Psychotherapy* said, “That the therapist should normally understand his


patient’s world and see the patient’s behavior from the patient’s own frame of reference is highly desirable.”

Ellis stopped short of embracing the empathy suggested by other personality theorists such as Carl Rogers, but he advocated addressing issues in context. Likewise, Aaron Beck in *Cognitive Therapy and the Emotional Disorders* discussed the unique needs of the depressed person and the wisdom of the therapist in seeing the context and styling the treatment accordingly. Beck said, “In the course of time, I found that tailoring a technique to selected characteristics of the depression syndrome as well as to the personality of the patient was far more effective than the previous approaches.”

Beck saw the practical side of understanding context as being more efficient and effective.

Context may be comprehended in various ways. William Glasser in *Reality Therapy* understood the concept of context as the therapist being intimately involved in the life of the client. He said, “First, there is the involvement; the therapist must become so involved with the patient that the patient can begin to face reality and see how his behavior is unrealistic.” This level of involvement is impossible without thoroughly understanding the client’s world and being willing to inhabit it with him for the course of therapy. Context may be viewed as a synonym for culture. When James comments on the desired attributes of crisis workers, he said they need “knowledge about the status and cultures of different groups; skills to effect culturally appropriate strategies that better

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match the cultures of crisis clients than do traditional strategies." This advocacy for knowing culture and being culturally appropriate makes a strong argument for the understanding of context and increases the likelihood that the client will be willing to engage because he feels understood and accepted. Older adults have spent their lifetimes in context. The concerned therapist would do well to spend time understanding that context.

Conclusion

Older adults who find themselves in crisis, depressed, and grieving the loss of a loved one may greatly benefit from the help of a trained therapist. Coming alongside another individual and sharing in his or her walk is a powerful tool to aid in recovery. This journey is not without considerations. Four factors must be addressed in this type of relationship: the model of treatment embraced by the helper, the attitude and ability of the older person to participate in his treatment, the theoretical perspective of the helper, and the context of the elderly person. The competent therapist will consider these issues as he proceeds in the helping process.

Group Processes and Dynamics

Introduction

Life takes place in the context of others. In most of life’s pursuits and encounters, relationships play a significant part in the dynamics of the process. From families of origin to extended family and friends on to colleagues and associates, a complex system of people surrounds each individual. Although life events happen to individuals, those

\[148\] James, 22.
individuals experience the events in the context of groups. The group may be quite large numbering into the hundreds or small consisting of two or three. Regardless of size, the group exerts influence on the individual. Groups are powerful. Sometimes group dynamics contribute to negative experiences and outcomes as in the case of gangs, riots, uprisings, and revolution. Conversely, groups are helpful and add to the value of the human experience as evidenced by churches, civic organizations, missionary societies, and organizations designed to deliver social services.

The following discussion will give an overview of the dynamics of group therapy in the treatment process. The goal for persons in group therapy is similar to those in individual counseling. Robert Doyle in *Essential Skills and Strategies in the Helping Process* said, “The overall goal of the counseling process is to help the client become a more effectively functioning person.” In individual counseling the counselor’s role is to assist the client by collaborating with him and facilitating the process of change. The group dynamic employs each group member in facilitating change. Healing happens in the context of others.

Background of Therapeutic Groups

Carl Rogers pioneered person-centered therapy partly in reaction to more mechanical forms of counseling and behavior change techniques. He embraced an environment where the individual was free to express his present thoughts and feelings as they related to everyday life. His understanding of the role of the counselor and the client were quite different from other views. Duane Schultz and Sydney Ellen Schultz clarified

Roger’s position in *Theories of Personality* when they stated, “The person, not the therapist, directs such change; the therapist acts to assist it.” Rogers considered the counselor a facilitator of the therapeutic process. The primary force for change rests within the individual. His approach was far less directive than others and was characterized by being value free.

Rogers sometimes worked with individuals who had closed themselves off from others and had become disconnected from the reality of everyday life. He felt that this detachment could be counteracted and that the person could reengage in relationships if the therapeutic process possessed a broader relational quality. The therapist and client relationship was not sufficient to represent the relational nature of daily life. In light of this perspective, Rogers developed the encounter group in the 1960s. Regarding Roger’s rationale, Schultz and Schultz explained, “Through the therapeutic process, people could develop or regain flexibility, spontaneity, and openness. With missionary zeal, Rogers wanted to bring this state of enhanced psychological health and functioning to a greater number of people, so he developed a group technique in which people could learn more about themselves and how they related to, or encountered one another. He called his approach the encounter group.” These groups had little formal structure in the typical sense. Group leaders were little more than facilitators and creators of an atmosphere where people were open to share. Although encounter groups eventually fell out of popularity to a great degree, they gave rise to other types of group counseling, including the support group. The key recognition in this type of therapy is the power of the social_________

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151 Ibid., 314.
group in promoting change within the individual.

Albert Bandura moved further in the direction of social interaction in learning new behavior. Russell Powell, Diane Symbaluk, and Suzanne Macdonald in *Introduction to Learning and Behavior* explained one of Bandura’s theoretical foundations when the authors wrote, “There is considerable evidence that people can improve their performance on many tasks, including sports, simply by watching others perform.”  

This observation is important to the study of therapeutic groups because it lends support to the belief that individuals may help one another. In a group or social context individuals may observe others who demonstrate a particular attitude or behavior and choose to replicate that behavior in their lives. Schultz and Schultz described observational learning when they clarified, “Rather than experiencing reinforcement ourselves for each of our actions, we can learn through vicarious reinforcement by observing the behavior of others and the consequences of that behavior.”  

Learning through interacting with others and observing the behaviors of others are the most powerful elements of group therapy. Josh Gerow in *Psychology an Introduction* wrote, “Modeling involves the acquisition of an appropriate response through the imitation of a model. In a therapy situation, modeling amounts to having patients watch someone else perform an appropriate behavior, perhaps earning a reward for it (called vicarious reinforcement).”  

These principles do not necessitate a group setting. They may occur between the therapist and the client. When groups are utilized

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153Schultz and Schultz, 382.

154Gerow, 484.
multiple opportunities are presented for the client to see appropriate responses. Several others may positively influence the client to choose a more functional and rewarding approach to life. Sheldon Rose in *Group Therapy – A Behavioral Approach* affirmed the usefulness of the group dynamic. Rose clarified, “The group gives the client an opportunity to learn and practice many behaviors as he or she responds to the constantly changing group demands. The client must learn to deal with the idiosyncrasies of other individuals. By helping others, the client usually learns to help him- or herself more effectively than when he or she is the sole recipient of therapy.”

Helping others, and the associated feelings of regard and significance, is rewarding to the group participant. Even into old age the concept of participating in the lives of others is powerful. Theodore Lidz, in *The Person*, addressed the importance of being focused outwardly in old age when he wrote, “The ability to look forward to a meaningful future, for others if not for the self, helps counter apathy and promotes alertness.” The focus on others assists the elderly in purposefully continuing to engage in life. This focus may be accomplished in a group setting, particularly some form of group where support for the other members is inherent.

**Group Support**

Emotional support is a crucial need for the older adult, especially when bereavement and grief are presenting problems. The support group or self-help group offers a venue for help and healing in a nonthreatening setting. Poindexter, Valentine, and

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Conway remark, “Support, assurance, and help can be given in a group setting, such as a support group, self-help group, or psychoeducational group. A group is simply three or more people who have gathered for a common purpose or goal. Not everyone feels comfortable sharing personal information in a group, but for many persons, groups are the best way to find support and encouragement from persons who are experiencing similar difficulties.”

In the context of common experiences and among their peers, older adults may gain significant insight and help in coping with life issues.

Although many groups are heterogeneous, for the older adult a homogeneous group is preferable. Rose explained, “Groups composed of persons with similar problems offer the advantage of one common treatment procedure, resulting in a clear savings of time.”

In this instance time is not the issue, but familiarity, trust, and a shared life experience are elements making the older adult more comfortable. The elderly tend to be more open with those their own age and with whom they share similar experiences. Merianne Corey and Gerald Corey in *Group Processes and Practices* explained, “Self-help groups are typically organized around a shared specific problem. Because of this common problem such groups more easily develop into cohesive units. They provide a support system that helps reduce psychological stress and gives the members the incentive to begin changing their lives.”

By sharing similar problems the group members will have an understanding of one another’s world from the first meeting.

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157 Poindexter, Valentine, and Conway, 11.

158 Rose, 17.

The Attitude of the Helper

Some helpers choose not to work with elderly clients. Not everyone is suited for this particular clientele. Acknowledging this preference is preferable to attempting to feign concern and understanding for people with whom the helper does not enjoy working. The helper must possess certain attitudes in order to work effectively with elderly clients. The following are ten attributes from a longer list from Corey and Corey.

- A genuine respect for people.
- A deep sense of caring for the elderly.
- An ability and desire to learn from old people.
- An understanding of the biological aspects of aging.
- Patience, especially with repetition of stories.
- Sensitivity to the burdens and anxieties of old people.
- The ability to get old people to challenge myths about old age.
- An understanding of the developmental tasks of each period of life, from infancy to old age.
- The ability to deal with extreme feelings of depression, hopelessness, grief, hostility, and despair.
- A working knowledge of the group process along with the special skills needed for group work with the elderly.\(^\text{160}\)

A worker who possesses these traits will find working with older people a unique, challenging, and rewarding endeavor. The older person will be able to discern whether the helper is genuine. His or her experiences have trained them to detect persons who are insincere.

\(^{160}\text{Ibid., 442.}\)
Necessary Skills for Helpers

Attitude alone will not qualify one to work as a helper. Certain skills are necessary in order to make one an effective agent of change. The following skills for facilitating effective groups were selected from Corey and Corey:

- **Active listening.** It is important to learn how to pay full attention to others as they communicate.

- **Reflecting.** This is the ability to convey the essence of what a person has communicated so the person can see it.

- **Clarifying.** It involves focusing on key underlying issues and sorting out confusing and conflicting feelings.

- **Summarizing.** When the group becomes bogged down or fragmented, the leader can then summarize and offer possible alternatives.

- **Facilitating.** This includes assisting members to openly express their fears, work to create a climate of safety, provide encouragement and support, involve as many members as possible, work toward lessening dependency on the leader, encouraging open expression of conflict and controversy, and helping members overcome barriers to direct communication.

- **Empathizing.** This involves being able to openly grasp another’s experiences and at the same time maintain one’s separateness.

- **Confronting.** Leaders must sometimes challenge specifically the behaviors of a group member and share how he feels about the person’s behavior.

- **Supporting.** This skill is necessary and appropriate when people are facing a crisis, when they are venturing into frightening territory, and when they are feeling uncertain about making changes.

- **Blocking.** Group leaders have the responsibility to block certain activities of group members, such as questioning, probing, gossiping, invading another’s privacy, and breaking confidences.

- **Diagnosing.** This includes the ability to appraise certain behavior problems and choose the appropriate intervention.

- **Evaluating.** Good leaders must evaluate the ongoing process and dynamics of a group.
Terminating. Group leaders must learn when and how to terminate their work with both individuals and groups.161 These skills allow the helper to successfully lead therapeutic groups. As with any other skill, practice and patience help the worker to develop more fully into an effective group leader. The group leader of older adults must be as proficient as with any other group. One must never diminish the required competency of a leader because the group composition is elderly.

Conclusion
The biblical literature review revealed that older adults made significant contributions to their community of faith while experiencing the difficulties of old age. Revered Bible figures struggled with age related problems including physical decline, loss, and loneliness. God placed persons of diversity within the church in order to compliment the community, serve one another, and complete the body of Christ.

The general literature review disclosed that many older adults experience adjustment problems due to declining health, diminished finances, and the loss of a sense of significance. Yet, life happens in a social context. Individuals can gain support, encouragement, and understanding from one another. They may also be challenged by their peers to experience life differently and more fully. Groups are powerful agents of change. New concepts and behaviors can be learned by observing group members who model those behaviors. Persons who lead support or self-help groups must possess significant personal character traits and certain skill sets. When the leader is equipped to adequately lead, the group will have a better likelihood of success.

161Ibid., 21-26.
CHAPTER 3

DESCRIPTION OF FIELD PROJECT

Preparation of the Project

Chapter 3 describes the field project. Chapter 1 presented a discussion of the context, opportunity, and purpose for the project. The proposed project was described and outlined including the scope and phases of the project. Chapter 2 involved building a theoretical schematic by reviewing biblical literature and general literature relating to the project. This chapter includes a discussion of considerations, planning, and preparation prior to the execution of the project.

Early Considerations

The first issue contemplated was the substantial number of mature adults in the congregation of First Baptist Church of Hendersonville, Tennessee. The membership included thirteen hundred persons over the age of sixty-five. Over six-hundred of these members participated in Sunday school each week. This population consisted of the most generous givers of finances and ministry time to the congregation and community. Mature adults were a significant force in the congregation.

Secondly, substantial numbers of mature adult widows were identified among the congregation. A search from the church automated database revealed eighty women who
were widowed within the past five years and who lived alone. Crisis care ministry opportunities were frequent. Funerals, memorial meals, and visits to bereaved families occurred repeatedly. The project director, who served as Minister to Mature Adults, had observed bereaved men and women struggling with their loss for several years. Although some continued to attend their Sunday school classes, Bible studies, mission groups, choir, and service projects, others had withdrawn from former activities. Some of these widows privately shared that they had experienced continued grief, loneliness, and mild depression. A number of them had begun taking an antidepressant to reduce their symptoms, yet they had not engaged in any type of counseling. An intervention strategy for these members was needed.

Early Conversations

A conversation with the leader of the Chosen Ministry, a ministry group of widows in the congregation, revealed a distinction between the younger and older widows. The older widows dealt with grief, loneliness, and sometimes depression. They had the full responsibility of caring for their homes, lawns, automobiles, and financial matters. Life was more complicated and difficult than before the death of their husbands. The younger widows had all of the same issues as the older widows in addition to other stressors including child rearing, insufficient finances, and having to work outside the home. Because of these real and perceived differences the two groups sometimes met for functions separately, the younger group emphasized how to cope with their issues and the older group highlighted issues peculiar to them. Although professional counseling was strongly recommended by the ministry leader, few of the women from either group actually initiated counseling appointments. Peer counseling was conducted informally as
the opportunity arose. Some widowed women in the congregation chose not to participate in the ministry at all. Consequently, they had even less support available to them.

The church counseling ministry offered individual and group counseling for children and adults. One adult group focused on bereavement and grief. A conversation with the leader of that group revealed that few older women participated in the group. Furthermore, group participation in general had never reached the level consistent with the perceived need. Methods for communicating the formation of new groups to the congregation were discussed. Notification typically consisted of two weekly notices printed in the Sunday worship guide and an announcement on the counseling center website. The curriculum utilized consisted of videos and a workbook discussion guide. The support group leader was given feedback from former participants that the video presentations were too long, and because the groups had been so small, discussion was quite limited. These factors presented obstacles necessitating further planning.

Identifying Group Components

The purpose of the project was to discover the effects of a strategic small group in helping to alleviate symptoms of mild depression among an older adult population at First Baptist Church in Hendersonville, Tennessee. The original premise was that participation in a small grief share group would reduce the symptoms of depressed mood reported by the members with both learning and social components contributing to this outcome. As the previous grief support group leader and the project director discussed necessary and desirable group components, four key elements emerged.
**Biblical Basis**

A biblical basis for the project was strongly asserted. By reviewing biblical literature relevant to this subject, clarity was given to the solid biblical basis for emotional healing. Scripture indicated that divine intervention in the form of physical healing did not always occur, and was apparently not always the will of God. Strong evidence suggested that emotional health and healing were part of the redemptive plan and enjoyed in the context of everyday life. Peace of mind was potentially a reality. Emotional peace and stability, confidence in God and the assurance that God has a well chosen and loving plan for the welfare of each Christian was fully in view. These pledges originated from the Word of God. Their strength resided in the strength of the character of God. Logically, a time for studying the Word of God was appropriate.

**Socialization**

A time for fellowship was necessary in order to begin to alleviate feelings of loneliness experienced by group members. The social components of the group process were not overlooked. Feelings of isolation were strong, but when group members felt understood, accepted, and loved, their thinking and feelings changed. Since socialization naturally occurs when groups assemble for sessions, the project director decided to elongate the time to include some light midmorning snacks and drinks. Additionally, the project director decided that socialization opportunities outside of the confines of the designated group meeting times would be encouraged and promoted.

**Structured Learning**

The next essential component was structured learning regarding how to effectively cope with bereavement and grief. The philosophical perspective of the project
The director was that feelings originate from thoughts and are consistent with those thoughts, not random and inexplicable. Only when thoughts change do feelings, and resultantly behaviors, change. The primary consideration of a structured learning segment involved group time not becoming a classroom lecture. Information was presented in a palatable manner that engaged the group members. Since adequate materials were available on the subject of bereavement and grief, it was unnecessary to create a new version. A review of the materials was necessary with editing in view.

**Group Discussion**

The project director decided that group discussion logically followed the structured learning segment. Interaction provided therapeutic benefits as the members affirmed, taught, challenged, and encouraged one another. Discussion time was important to a positive outcome and was not restricted, because discussion and socialization are enmeshed and share mutual benefits. Co-leaders acted as facilitators, not experts.

**Group Format**

Having discussed these elements, a decision was made to utilize the following format: unstructured welcome and socialization opportunity, Bible study and prayer time, structured learning, and group discussion and encouragement. These key components in logical sequence proved effective as a therapeutic intervention.

**Appraisal of Curriculum**

The Grief Share material as appraised by the project director was a biblically based, psychologically sound, well planned curriculum. However, problems were inherent in light of the objectives of the project. The first problem was the length of the
video presentations. They were too long to allow for the other components of the group. In order to overcome this obstacle the video presentations were edited to highlight a very specific component of the discussion. The counselor who had led previous groups agreed to review the materials and accomplish the editing. The accompanying workbook was thorough, but more involved than necessary. A decision was made to eliminate the workbook altogether. The choice made it possible to offer the group free of charge to the participants. The curriculum was designed for thirteen working sessions, a typical number of meetings for support groups; however, thirteen was believed to be longer than the group participants would choose to commit. The adjusted schedule included an introductory session, eight working sessions, and a termination session.

Participant Contact

Since established methods for notifying possible participants had previously failed to yield a desirable number of group members, an alternative method seemed necessary. A list of possible participants was established by utilizing the automated church system. Eighty women fit the profile. The project director reviewed the list and selected widows with whom there was an established relationship. Only twelve calls were made before ten widows agreed to participate in the group project. By leveraging an established relationship widows were more willing to participate in the group project.

Location and Time

Many mature adults had strong preconceived notions regarding professional counseling. Generally, they considered psychological counseling suspect in effectiveness and tended to regard persons who participated in counseling as being weak or needy. For this reason the meeting location was strongly considered. The Babb Center church
counseling ministry was located in a free standing, two story building on the edge of the campus, housed fifteen counseling offices, two group therapy rooms, and a chapel. The building was utilized only for counseling and was a busy location most afternoons and evenings.

The main campus structure housed the worship center, educational buildings, office space, chapel, fellowship and dining halls, family ministry center, and library under one roof or by connecting enclosed breezeways. The main structure was not associated with the professional counseling ministry in the minds of the congregation. About three hundred yards separated the counseling center from the main structure.

For reasons of bias against counseling, and therefore a possible refusal to participate, utilizing a space other than the Babb Center for group meetings was considered. Several options were possible in the main complex, and all of the prospective participants were familiar with those spaces. In the end, however, the group counseling room at the Babb Center was selected. The first reason for making this decision was a desire to break down barriers. Helping the participants understand that counseling was legitimate was an adjunct benefit of the project. Familiarizing them with the counseling center facility encouraged them to feel more open to receive counseling services in the future and to recommend counseling to their friends. By locating the group in the building, participants came into contact with other counselors, administrators, and staff of the center. They began to think of real people doing a ministry rather than just a vague and nebulous perception of counseling. In addition, the group room was an excellently designed space. The meeting room was beautiful, quiet, easily accessible, and seating was more than adequate.
The time consideration was fairly straightforward. A balance between not enough and too much was the goal. One hour was simply not enough time to be thorough. Two hours was a long time for mature adult ladies to participate in a group session. A decision was made to meet for one and one half hours each Tuesday morning from 10:00 – 11:30. This time frame allowed for further socialization and luncheon opportunities.

Assessment Tools

Assessing project outcomes was essential. The object of assessment was self-reported depression caused by loneliness. Requirements for an appropriate instrument, in addition to reliability and validity, included: short, simple, easy to administer and interpret, cost-efficient, and user-friendly with a mature adult population. The UCLA Loneliness Scale and the Beck Depression Inventory II met those requirements. Due to this project director’s prior familiarity with these instruments, the decision was not a difficult consideration. In order to maintain project integrity, a counseling center psychological examiner was asked to administer and interpret the information collected from participant self-reports. Individual participant reports were confidential. Only the examiner and the participant were privy to identities. Self-reported information was gathered from group participants and selected non-participants prior to treatment and at the conclusion of treatment.

Execution of the Project

With the preparatory work complete the time to execute the project arrived. It was time to utilize a small group to alleviate symptoms of mild depression in an older adult population at First Baptist Church of Hendersonville, Tennessee. The following
discussion involves three areas: group meeting schedule, group participant attendance, and group social events.

Group Meeting Schedule

Whether or not the time of year had a significant bearing on the execution and outcome of this project remains unknown. Since the project began in late September and ran through the middle of December, the holiday season with attending issues was a consideration. The group meeting schedule was:

- September 27 Meeting # 1 Introduction to group, secure consent forms
- October 4 Meeting # 2 Working session, self-reporting
- October 11 No Meeting Fall break, no church weekday activities
- October 18 Meeting # 3 Working session
- October 25 Meeting # 4 Working session
- November 1 Meeting # 5 Working session, support group lunch out
- November 8 Meeting # 6 Working session
- November 15 Meeting # 7 Working session
- November 22 No Meeting Thanksgiving break, no weekday activities
- November 29 Meeting # 8 Working session
- December 6 Meeting # 9 Working session
- December 13 Meeting # 10 Self-reporting, brunch, debriefing

Group Participant Attendance

On the first meeting day all ten of the women who had agreed to participate were present. In addition, two women who had read the announcement in the church worship guide came to the meeting. The purpose of the group and the project were explained and they chose to participate. The day after the initial meeting, one of the original ten women called and withdrew from participation. She became one of the five non-participants from
whom self-reported information was gathered. The group stabilized at eleven and participant attendance remained high for the remainder of the meetings. Some women were absent for doctor’s appointments and vacations, but those women gave prior notification. The group participant attendance ranged from seven to eleven members for each meeting.

Results of the Project

Information gathered from participant self-reports supported the initial assumption that small group participation would help to alleviate mild depression caused by grief and loneliness in a mature adult population. Those outcomes are specifically outlined in the Participant Weekly Evaluation, UCLA Loneliness Scale, Beck Depression Inventory II, and Participant Final Evaluation sections which follow. The project director’s observation of the participants as they interacted with each other in group and socially was consistent with participant self-reports. Those two factors contributed to the concluding supposition that the small therapeutic group treatment had been successful in helping to reduce self-reported feelings of mild depression caused by grief and loneliness.

Group Social Interaction

The project director observed group participants bonding during the opening minutes of the first session. No participant had a prior relationship with every other group participant. At least half of the participants had never met each other or had only seen one another at the church worship meetings. As participants entered the group meeting room, they introduced themselves to one another. Some exchanged hugs. A sense of commonality among the members was discernable. No awkward encounters were observed as sometimes occurs with support groups.
After introductory remarks were made by the co-leaders in the first session, the participants commented regarding the purpose of the group and their personal experiences. Quickly, they interacted with one another by acknowledging an understanding of the other’s situation, lending emotional support, and encouraging one another. By the end of the first hour of the first session the group demonstrated working characteristics of a group that had met for several sessions. The co-leaders later discussed this group dynamic and acknowledged that they had never seen a group form cohesiveness so rapidly.

At the conclusion of the second meeting some group members openly asked others to have lunch. Invitations were made and accepted. Meeting times were intentionally coordinated to accommodate lunch gatherings but had purposefully not been suggested by the co-leaders. During the third group meeting, the members agreed that they wanted a group contact directory which was given to them at the fourth meeting. A luncheon was planned and hosted by the project director after the fifth group meeting. It took place at a local restaurant. All eleven of the group members participated, and the lunch lasted for almost two hours. Members obviously enjoyed one another’s company. Among several of the participants group lunches became a common practice.

On the final group meeting day after the participants completed their self-reports, a brunch was provided in the meeting room. Ten participants were present and one had a doctor’s appointment. During the brunch, a spontaneous conversation began regarding wanting to meet informally the following month. Group members planned a lunch meeting for the third Tuesday in January. The meeting was scheduled without any prompting from the co-leaders.
This group displayed special and unusual social qualities. They were committed to the project being conducted, to the group in general and decisively to one another. Factors contributing to the camaraderie were their common life situations, their shared relationship with the project director, their mature age, and their mutual faith. Whatever the individual reasons, the group displayed extraordinary social cohesiveness.

Participant Weekly Evaluation

At the conclusion of each session, participants completed a Participant Weekly Evaluation of the group components.\(^1\) The evaluation utilized a five-level Likert scale (1 indicated Strongly Disagree and 5 indicated Strongly Agree) evaluating the social component, devotional and prayer time, video presentation, group discussion, and the overall productivity of the session. Eight working sessions were evaluated.

The composite results revealed mean scores of:

- Social component enjoyable: 4.9
- Devotional and prayer time meaningful: 4.8
- Video presentation interesting: 4.6
- Group discussion helpful: 4.7
- Overall productivity: 4.8

Not surprisingly, the most favorable ratings included the social component, Bible and prayer time, and group discussion, respectively. The least favorable was the video component, yet with strong agreement that it was interesting. All sessions were overwhelmingly deemed productive. These results were consistent with the observations of the group co-leaders.

Since the original premise was that these participants were lonely, the elevated

\(^1\)See Appendix A for a sample of Participant Evaluation.
rating for the social component was expected yet not anticipated as the highest rated component. They deemed their group counterparts pleasant and encouraging. The participants consistently demonstrated that they enjoyed the company of the group and the evaluation results showed concurrence.

Beck Depression Inventory II

The project director initially assumed that an individual’s mild depression caused by grief and loneliness would be alleviated by participation in a small therapeutic group. The most dramatic demonstration of that assumption being correct was the self-reported participant information gathered from the BDI II. Eleven group participants and five non-participants furnished self-reported information prior to the second and the tenth sessions. Eight working sessions, or twelve hours of therapeutic intervention, elapsed between gathering information from the group participants and non-participants. The BDI II indicated that those who had participated in the therapeutic small group reported feeling less depressed, while non-participants reported feeling more depressed than at the beginning of the project.

The Interpretative ranges for the BDI II are:

<table>
<thead>
<tr>
<th>Depression Level</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal depression</td>
<td>0-13</td>
</tr>
<tr>
<td>Mild depression</td>
<td>14-19</td>
</tr>
<tr>
<td>Moderate depression</td>
<td>20-28</td>
</tr>
<tr>
<td>Severe depression</td>
<td>29-63</td>
</tr>
</tbody>
</table>

Table 1.1. The results of the BDI II for participants and non-participants:

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Range</td>
<td>2-26=24</td>
<td>1-22=21</td>
<td>1-15=14</td>
<td>2-22=20</td>
</tr>
<tr>
<td>Median</td>
<td>14.5</td>
<td>7</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>Mode</td>
<td>19</td>
<td>9</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mean</td>
<td>14.083</td>
<td>8.636</td>
<td>9.6</td>
<td>13.4</td>
</tr>
</tbody>
</table>
While group participants began the project by reporting their felt depression at the low end of the mild depression range, non-participants began just above midpoint of the minimal depression range. Thus, group participants began the project feeling slightly more depressed than non-participants. Since all were chosen according to the same criterion these differences may have been influenced by random assignment.

Self-reports indicate that when the project concluded, group participants felt less depressed while non-participants reported feeling more depressed. In fact, group participant ratings decreased by almost half. The therapeutic intervention, including the socialization, was believed to account for the drop in depression ratings for group participants. The rise in the ratings of the non-participant group demanded exploration. One possibility was that the project occurred during Thanksgiving and approached Christmas. That non-participants felt more depressed during the holiday period was reasonable and makes the drop in felt depression among participants more dramatic. Another possibility was that by reporting their feelings of depression non-participants began to think about their situation as widows and with no treatment became more depressed. With either possible explanation, the fact that the therapeutic group intervention made a positive difference was well established.

**UCLA Loneliness Scale**

An assumption was made that both the therapeutic group participants and non-participants would initially report elevated feeling of loneliness. Further, the project director presumed that participants of the ten week therapeutic support group would report decreased loneliness levels and non-participants would not report significantly
different levels of felt and expressed loneliness. Those presuppositions were supported by information gathered from the widow’s self-reports.

Interpretative ranges for the UCLA Loneliness Scale are:

- Low experience of loneliness: 0-29
- Normal experience of loneliness: 30-40
- High experience of loneliness: 41-59
- Severe experience of loneliness: 60+

Table 1.2. The test results of the UCLA Loneliness Scale for participants and non-participants:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Range</td>
<td>24-55=31</td>
<td>24-53=29</td>
<td>24-55=31</td>
<td>23-51=28</td>
</tr>
<tr>
<td>Median</td>
<td>42</td>
<td>38</td>
<td>30</td>
<td>32</td>
</tr>
<tr>
<td>Mode</td>
<td>X</td>
<td>43, 25</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mean</td>
<td>41.25</td>
<td>37.36</td>
<td>36.8</td>
<td>36.4</td>
</tr>
</tbody>
</table>

Therapeutic group participants began the project at the low end of the high experience of loneliness range. This level of reported loneliness was consistent with their demonstration of a mild depression level on the Beck Depression Inventory II. Their level of loneliness was accounted for by their present circumstance of widowed and living alone. Non-participants began at the mid-level of the normal experience of loneliness range. Their lower level of expressed loneliness was consistent with their initial level of lower depression. Although their circumstances were the same, the therapeutic group participants initially reported higher levels of depression and loneliness than non-participants. This difference was accounted for by random assignment since all widows met the same criteria.

Levels of self-reported loneliness for the therapeutic group participants dropped substantially during the course of the project to within the mid-range of the normal experience of loneliness. After eight working group sessions, they moved to a lower range of felt and expressed loneliness. This drop in loneliness levels was logically
attributed to the experience of group therapy. Non-participants levels of loneliness moved lower insignificantly. They began and ended the project at the same level of felt and expressed loneliness. Their failure to decline in loneliness highlights the decrease in expressed loneliness of group participants. The only discernable difference in the two groups during the course of the project was the therapeutic group experience.

Participant Final Evaluation

As part of the project exit strategy, therapeutic group participants completed the Small Group Project Final Evaluation. The evaluation utilized a five-level Likert scale (1 indicated Strongly Disagree and 5 indicated Strongly Agree) assessing six statements.

Small Group Project Final Evaluation results were:

- I can better cope with my grief. 4.4
- I have been encouraged by the group. 4.5
- I have developed new relationships. 4.7
- I feel better emotionally. 4.9
- I would recommend this group. 5
- I would consider further group participation. 4.3

The overall reaction to the group experience was positive. The strongest two areas were that they felt better emotionally as a result of having participated in the therapeutic small group and that they would recommend this group to a friend. That they felt better emotionally was consistent with their self-report. The lowest rating concerned further participation in the group. Clearly, the participants enjoyed one another’s company, developed new relationships, and felt better after participating in the group. The slightly lower composite rating for further group participation was explained by their desire to meet together again but not in a therapeutic setting. After completing this evaluation,

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2See Appendix B for a sample of Small Group Project Final Evaluation.
participants decided collectively to meet again in January. All participants concurred.

**The Project’s Contribution to Ministry**

Utilizing a small group to alleviate symptoms of mild depression among an older adult population at First Baptist Church of Hendersonville, Tennessee was conceptualized by observing real life situations. In this project, theory and reality were united in order to find a viable solution for hurting individuals. Beyond the initial benefit to the participants, the project contributed to the Ventures Mature Adult Ministry, the Babb Center Counseling Ministry, and the congregation as a whole.

**Contribution to Participants**

As observed by the co-facilitators from the onset of the project, the participants demonstrated a sense of commitment to the project and to one another. They functioned like a team. They expressed that their common experiences, shared status, and mutual faith broke down barriers to the formation of a cohesive group. The members engaged, encouraged, and consoled one another. They shared difficult personal stories and uplifting personal victories. They worked together during the initial session and continued throughout the course of the project. When they collectively decided to meet again as a group they took a significant step toward continuing the healing process together.

Group evaluations demonstrated that the participants found the social experience enjoyable, the devotional and prayer time meaningful, the group discussion helpful, and the overall group experience productive. Their self-reported depression levels revealed that they actually felt less depressed at the conclusion than when they began the project. The Participant Final Evaluation concurred with their depression report that they
perceived feeling better. As disclosed in self-reports of the participants, the therapeutic group was helpful in elevating their mood. Additionally, reports illustrated that their sense of loneliness declined significantly and their sense of well being was heightened. Participant circumstances at the beginning of the group and at the end of the group were exactly the same. Group participant feelings about those circumstances changed.

During the course of the project, participants commented about their desire to help others. They evaluated the various group components based on what they found helpful and what they believed would be helpful to other widows. This commitment may have been a contributing factor in facilitating their feeling better. By taking the focus entirely off their circumstance and giving them an opportunity to assist in devising an effective treatment model, their depression and loneliness decreased. They took pleasure in creating a tool to benefit someone else.

Contribution to the Ventures Ministry

The Ventures Ministry encompassed all mature adults who served on one of twelve ministry teams at First Baptist Church of Hendersonville. Hundreds of volunteers participated on a regular basis. The ministry was mission driven rather than event driven. There were few activities that were done simply for the entertainment of the group. The Ventures Ministry was outwardly focused. This project was consistent with such a philosophy of ministry.

The discovery of a tool to effectively decrease depression caused by grief and loneliness in a mature adult population can be generalized to other groups in other scenarios. These findings have the potential to help those outside of the confines of a particular congregation. A new ministry team may be developed based on the data
collected in the project. Project participants could lead similar groups in the same context, in neighboring congregations, or in any of the several assisted living and nursing home facilities in the area.

**Contribution to the Babb Center Counseling Ministry**

The Babb Center was well established as a first class counseling facility for the entire community. Members of the First Baptist Church congregation comprised only about 20 percent of those served. Individual and group counseling was available, but the vast majority of counseling was done individually. The conclusions reached in this project could aid in developing an excellent group model for treating mild depression caused by loneliness in a widowed population.

Additionally, an older population was served in this project. None of the participants had initiated counseling for themselves. They had not gone to the Babb Center even though they supported its purposes. The stigma of counseling and the Babb Center was changed by participation in this project. Participants reported that they would recommend this group to their friends. Older adults do not generally recommend treatments unless they believe in them. When mature adults start recommending group treatment methods their friends will listen. The Babb Center may become less of an oddity to this graying population.

**Contributions to the Congregation**

Self-reports indicate that the project was helpful to the eleven women who participated in the therapeutic small group. They felt better and were less lonely at the conclusion of the project than at the beginning. When members of the congregation experience healing, the congregation is made better and stronger. Congregations are
communal in nature. Experiences are not isolated and people are not insulated from one another. Like a body, one part influences another part. By these women feeling better, being part of something that they view as positive, and telling others about what happened to them, the body will feel the positive effects of their healing.

The women in the group modeled new behavior as evidenced by participating in group therapy and speaking openly and positively about their experiences with others in the congregation. By doing something positive about their unfortunate circumstance they modeled behavior that may help to dispel stereotypes of elderly women complaining but not doing anything about their situation. God may use this experience to move others to seek His healing.
CHAPTER 4

PROJECT SUMMARY

The following summation represents an amalgamation of the vital elements of previous chapters, an assessment of project effectiveness, and a discussion of potential further research and implementation of utilizing small groups to promote healing among a mature adult population. Implications of the results of this project were both immediate and expansive. Members of the First Baptist Church of Hendersonville benefited from what was learned through the project. Additionally, project components may be altered to accommodate other populations in a variety of settings.

Evaluation of the Project

An accurate and fair appraisal of any endeavor is prudent. This project proposed that utilizing a small support group would alleviate the symptoms of mild depression caused by grief and loneliness in an older adult population. Christian congregations tend to utilize small groups as modeled in the New Testament. Relationships formed in small groups are beneficial to spiritual growth and discipleship. Secular psychologists suggest that support groups empower the individual to become a helper, concurrently helping himself. While there appears to be an assumed validity to these premises, assumptions are inadequate to build viable models for genuinely helping people.
Observing the participants in the therapeutic group, collecting their self-reports of feelings of depression and loneliness, and assimilating their information were crucial to the endeavor’s validity. The reports of the participants indicated that the initial project assumption was correct. Support group participants reported lower depression and loneliness levels after having completed the course of treatment. Reported depression levels among non-participants increased and loneliness scores remained constant during the project. Participant self-reports suggest a positive correlation between participation in the small therapeutic support group and lower levels of felt depression and loneliness.

Participant self-reports concluded that members of the group felt better emotionally after completing the small support group project. Additionally, they found the social component and relationship development opportunity enjoyable and encouraging. Participants deciding to continue meeting on a monthly basis supported their belief that the group was helpful and meaningful. Based on the reports of participants, the project director believed that a tool for helping alleviate depression caused by grief and loneliness in a mature adult population was identified.

Keys to Project Effectiveness

Multiple variables may have influenced the project’s success. Five are both obvious and noteworthy: (1) a biblical foundation, (2) project relevance, (3) a personal invitation to participate, (4) adequate curriculum, and (5) appropriate measurement instruments.
A Biblical Foundation

Foundational to the selection and implementation of this project was the belief that God desires for His people individually and collectively to experience His redemptive healing. God redeems and restores those who belong to Him. Healing does not always manifest itself in the realm of the physical body. People become ill and everyone dies. That fact does not mean that God is unconcerned about the welfare of His children. In Psalm 119:122, David asked that God “Guarantee Your servant’s well-being.” David was not reprimanded for his request. In John 5:6 at the pool of Bethesda, Jesus asked a man who had been physically sick for thirty-eight years, “Do you want to get well?” That question was not meant rhetorically. That God was concerned about the entirety of one’s being was demonstrated when David said in Psalm 116:7, “Return to your rest, my soul, for the Lord has been good to you.” Upon the foundation of God’s desire for His people to experience wholeness, this project rests.

Project Relevance

The relevance of this project provided the impetus necessary for its execution and completion. In a setting where eighty women in the past five years became eligible for the criteria for widowed and living alone, the need was obvious. The ministry of the project director was heavily involved in pastoral care, and one of the most noticeable areas was ministry to the dying elderly and their subsequent widows/widowers. The women who participated in the project did more than fit criteria; they were hurting and needed to be helped. The strong desire to alleviate suffering propelled the project director, the co-facilitator, and the psychological examiner to devote time and energy to the women who participated in the project. Regardless of the findings, ministry projects
are not successful if people do not benefit. In the case of this project, participant reports supported the initial project assumption, but more important was the fact that women reported feeling better emotionally and coped with their grief more effectively because they participated in the therapeutic support group.

**A Personal Invitation to Participate**

Ministry initiatives are irrelevant if no one participates. On prior occasions similar groups were advertised with minimal response. One participant does not comprise a group, and two are grossly inadequate and awkward. Yet, this scenario was the typical outcome from simply placing a notice in the church worship guide. When initiating contacting possible participants was considered, the project director was concerned that a prior relationship would pollute the outcome of the project. However, by not initiating and inviting widows, the group may have never formed for lack of participants.

After weighing the options the decision was made to call potential group members and extend the invitation to participate in the project. Because of the prior relationship with the project director twelve calls netted ten participants. This outcome would not have happened with a general notice for group participants. Additionally, the women who responded positively remained engaged in the group for the entirety of the scope of the project. Dropout is a common factor in support group scenarios but not a variable in this project. In all probability, the prior relationship and personal invitation to participate played a significant role in group member retention. In order to keep the project unpolluted a co-facilitator was acquired and a separate psychological examiner utilized.
**Adequate Curriculum**

Adequate and appropriate curriculum is central to the learning experience, and the goal of the group process involves learning new behaviors. Good curriculum enhances the learning experience. The curriculum previously utilized by the counseling ministry staff to guide grief support groups was characterized as excessive for purposes of this project. The detailed workbook was rejected and disproportionately lengthy videos aggressively edited. Had those elements not been revamped, the project may have never been completed. Even with editing the videos, these mature adult participants were stretched to remain engaged. Members of the group wanted to interact with each other which was a primary purpose of the group, therefore, ample time was given for group interaction. The outline from the workbook and videos were maintained and worked very well, but only a brief clip from the video was shown each week before launching into group discussion.

**Appropriate Measurement Instruments**

Projects must be subject to assessment in order to discern their effectiveness. W. Bruce Walsh and Nancy E. Betz said, “In an applied sense, the assessment process has four parts: the problem, information gathering, understanding the information, and coping with the problem.”\(^2\) The problem addressed in this project was mild depression caused by loneliness in a mature adult population of widows. Several instruments available to psychological examiners may be utilized to capture and help interpret depression ratings. The challenge for this project involved an instrument that would be sensitive in a rather

short term scenario. Some instruments were excellent but did not effectively report
differences over such a short duration. Additionally, an appropriate instrument had to be
user friendly, relatively short, and not cost prohibitive. Since the project director had
utilized the Beck Depression Inventory II when engaging in counseling, the instrument
was quickly indentified as appropriate. After having researched the availability of an
adequate loneliness scale, the UCLA Loneliness Scale was chosen. The participants gave
feedback that was positive about the ease of utilizing the instruments for self-reporting.
These instruments were excellent for this particular population. They were easily
administered and interpreted, sensitive to change over a short period of time, and
affordable to purchase.

Keys to Project Improvement

Although the project dynamics worked quite well, some minor alterations may be
made to enhance future groups. First, the group was facilitated by two co-leaders who
had never experienced having a spouse die. One may empathize with the widows but not
be able to identify significantly with them. The group would be better facilitated by at
least one co-leader having experienced what the group members have experienced. Such
stipulations are fairly typical in other support groups such as Alcoholics Anonymous.

At the midpoint of the project the co-leaders discussed regret for not asking the
participants to keep a journal. Journaling is known to be quite therapeutic even outside of
a counseling purview. In all likelihood the discussion would have been enhanced if the
participants had written down their personal internal cognitions between sessions.
Standardized journaling notebooks should have been provided at the initial session. A
time for voluntary readings from those journals should have been an element in each session.

Conducting the group when no project or study is involved may enhance the experience for the widows. Each participant gave informed consent to be a part of the project study. Although this item was not mentioned again by the co-leaders during the working sessions, the participants continued to make references to the project. They were enthused to be part of something that would potentially help others as well as themselves. What was uncertain was how much effect the awareness of being studied had on the group experience. The Hawthorne Effect, a change of participant behavior due to being studied, should not have been a factor in reporting outcomes, but the question remains as to how much the participants were distracted by the study and self-reporting.

The group met ten times. These sessions included an introductory session, eight working sessions, and a wrap-up session. An additional two working sessions should be added to the next group. The group began working more quickly than most, yet another two sessions would have been helpful to cover all the pertinent topics. Ten sessions allowed for completing the group project prior to Christmas, but the time was somewhat insufficient for discussing all the pertinent topics related to grief recovery.

**Implications of the Project**

There were four obvious implications derived from the findings of the project. The first implication was financial. Participation in the small support group helped to decrease the level of loneliness felt by group members. Widows who lived alone were targeted for group membership. Their situations did not change during the course of the group experience, yet they became less lonely. Several group members reported that
feelings of loneliness had provoked them to do things atypical of their behavior prior to being widowed. One reoccurring example was going to the mall and shopping. Several women reported shopping excessively as a form of recreation. Financial strain, worry, and guilt accompanied some of the shopping binges. The group helped to identify much of their shopping behavior as a symptom of being lonely, and the group provided an alternative to shopping recreationally.

The second implication regarded stigma. A tool for helping to alleviate symptoms of mild depression without the stigma of medical attention or professional counseling was identified. Small group participation helped to decrease felt and expressed depression among the participants. The group members were less depressed at the conclusion of the group. A reduction in depression without the aid of medication or costly individual counseling was a good outcome. This decrease occurred within a relatively short period of time and cost the participants nothing other than their time. For older adults this was incredibly exciting news. Older adults tend to live on frugal budgets and have a sufficient amount of time to devote to worthwhile endeavors. Additionally, the implication that depression does not necessarily have to accompany old age was encouraging. Small support groups may be established in various surroundings such as assisted living facilities and in some nursing home situations. Many elderly may benefit from having a similar experience.

The third implication involved community building. Participants were encouraged by one another, could identify with one another, and enjoyed socializing with one another. Participants developed a kinship during the course of the group. They shared private thoughts and struggles without embarrassment. They did not feel pitied but understood. Group cohesiveness developed quickly and appeared to be ongoing past the
group parameters. This finding supports utilizing affinity groups for building community in a broader context.

Lastly, there was an implication for enlisting more ministry volunteers. When people feel better emotionally they participate in more life events. They tend not to isolate themselves from the rest of the world. By participating in the therapeutic small group experience the group members began to feel better and to some extent increased their engagement with others. Logically, this engagement could carry over to their church ministry involvement. Since retired older adults have significantly more time to contribute than those who are working every day, they make excellent ministry volunteers, but attempting to recruit depressed individuals may be unproductive. Depressed people contribute little personally to ministry and mission efforts. Those individuals who are helped to feel better through a small support group should make more ministry contributions. Further, the project director believed that by making ministry contributions the individuals would continue to increase their sense of well being.

**Recommendations for First Baptist Church, Hendersonville**

The project director, as the Minister to Mature adults, made the following recommendations to the leadership of the congregation. First, a strong ongoing relationship between the mature adult ministry and the counseling ministry appeared prudent. Findings from the project supported the benefit of mature adult involvement in support groups. By developing an open relationship with the counseling ministry, some of the stigma attached to counseling was dispelled for the older adult. At least one grief support group should be offered each semester that targets an older population.
Secondly, Mature Adult Sunday school teachers were apprised of the results of the project. Some level of training to identify individuals who are lonely and depressed was advised. Teachers would be wise to know whom to refer and what the process involves. Specific teachers may be trained to utilize some support group techniques in their individual classes, especially those classes comprised of the population of the project. Classes that focus on building community may be particularly beneficial to specific individuals who need that atmosphere.

Lastly, a new ministry opportunity was identified for launching similar small support groups in the community. Several facilities in the city that cater to the elderly would gladly open their doors to volunteers from the congregation. These therapeutic groups could significantly help to raise the mood levels of their patients. Large numbers of older adults could be helped to feel less lonely and less depressed. Since congregational group leaders are faith based there would be an excellent opportunity to share one’s faith openly in group.

**Recommendations for Future Study**

The reported outcomes of the project were consistent with initial assumptions, but further study may answer other questions. First, both the small group participants and non-participants were homogeneous in nature. All participants were mature adult widows who live alone. What would have happened if the group had younger and older widows participating? Would they have bonded relationally and been as social as the homogeneous group? Would the same results occur with a group of mature adult men who are widowers? Would men be as likely to discuss their loneliness as women? Would
a similar support group comprised of men and women be plausible, or would that dynamic be counterproductive?

Secondly, a longitudinal study of the benefits of the small support group would be helpful. The immediate benefit was noted, but whether the elevated mood lasts indefinitely remains unknown. Perhaps there should be an ongoing open group where former participants could attend as they feel the need. By following participants for twelve months after group participation further recommendations could intelligently be made.
CONCLUSION

The purpose of this project was to utilize a small group to alleviate symptoms of mild depression in an older adult population at First Baptist Church of Hendersonville, Tennessee. The project was driven by the ministry realities of the project director, the Minister to Mature Adults. Among the high concentration of older adults in the congregation were numerous situations involving life changes and challenges that presented adjustment difficulties. In many instances grief and loneliness had cut a destructive path across the landscape of their lives. Some older adults were in a state of crisis and others had settled into depression and become lethargic regarding life. These individuals were neither experiencing the satisfaction of living life fully, nor being as productive as possible in ministry opportunities. They were experiencing dysfunction and the body of Christ was not receiving the benefit of their potential. The project was never purely theoretical in nature, but grounded in the reality that people were hurting and needed legitimate help.

The philosophical and theological underpinning of the project director embraced the belief that God desired to comfort His people in times of turmoil and apparent defeat. Solace could come from God directly through His Spirit, through the Word which is alive and active, through His people collectively as the body of Christ, or through the intervention of a small faith focused group of co-sojourners. The project evidenced the appropriation of all these means to assuage the grief of a particularly vulnerable part of the body of Christ, a group of elderly widows.
The apostle Paul exhorted in 1 Timothy 5:3, “Support widows who are genuinely widows.” James described ministry to widows as being “pure and undefiled religion” in James 1:27. Through the execution of the project the project director gleaned considerable insight into the personal struggles of elderly women who grieved the loss of their husbands. In some cases there were no surviving members of their families. The depth of their loneliness was sometimes overwhelming. Generally, they found a modicum of support among their Christian friends. Specifically, the widows looked to the Lord to comfort and sustain them. Theirs was a practical faith in the Lord to meet a real and ongoing need in their life. When they met together in the group their faith was enhanced and multiplied. The biblical concepts of relationship and togetherness were brought to light. When the widows sensed that others cared enough about them to minister to them they were quite appreciative. For the project director, the project highlighted the duty and privilege of the body of Christ to engage in meaningful ministry to widows, and led to dialogue and planning for future ministries to this segment of the church.

Outcomes are important to any project. The initial project assumption proposed that a therapeutic group experience would help to alleviate symptoms of mild depression caused by grief and loneliness among the target population. A successful project could have been executed, assessed, and reported without a positive outcome for the participants. In fact, many historically significant discoveries were made from apparent failures. Had the project been purely academic, negative outcomes would have been acceptable. However, by design, the Doctor of Ministry project concerned people, and outcomes were crucial regarding the lives of others. Therefore, when the participant self-reports indicated lower depression levels as a project outcome; that meant that people were helped to feel better than they felt prior to their project participation. Similarly, self-
reports indicated lower loneliness levels as a project outcome which signified that people felt less alone than before the project was initiated. The project director was pleased to issue those reports, but more deeply satisfied to understand that people benefited from their participation in the project.

The project captured the attention of other widows among the congregation and church staff who witnessed positive outcomes. Unsolicited personal testimonies from group participants led to inquiries regarding the establishment of another group. Two weeks after the conclusion of the small group project, an identical group was calendared for August 2012. This project became an opportunity to move the mature adult ministry at First Baptist Church of Hendersonville, Tennessee to a more holistic approach to ministry, caring for both the spiritual and emotional needs of individuals.
Appendix A

PARTICIPANT EVALUATION
GROUP # _____

Answer Options:

1. Strongly Disagree
2. Disagree
3. Neither Agree or Disagree
4. Agree
5. Strongly Agree

The social time today was enjoyable. People are pleasant and encouraging.
1 2 3 4 5

The devotional and prayer time was meaningful. It helped me focus on God’s activity in my life.
1 2 3 4 5

The clip from “Grief Share” was interesting. I could relate to the topic.
1 2 3 4 5

The group discussion time was helpful. I heard something that might work for me.
1 2 3 4 5

Today’s session was productive.
1 2 3 4 5

Comments:
Appendix B

Small Group Project Final Evaluation

Answer Options:

1. Strongly Disagree
2. Disagree
3. Neither Agree or Disagree
4. Agree
5. Strongly Agree

I can better cope with my grief because of my group participation.
1 2 3 4 5

I have been encouraged by the other group members.
1 2 3 4 5

I have developed new relationships by participating in the group.
1 2 3 4 5

I feel better emotionally because I have participated in the group.
1 2 3 4 5

I would recommend a similar group to my friends who are grieving.
1 2 3 4 5

I would consider participating in the group if it continued to meet.
1 2 3 4 5
Appendix C

Beck Depression Inventory II

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
   0 I do not feel sad.
   1 I feel sad much of the time.
   2 I am sad all the time.
   3 I am so sad or unhappy that I can’t stand it.

2. Pessimism
   0 I am not discouraged about my future.
   1 I feel more discouraged about my future than I used to be.
   2 I do not expect things to work out for me.
   3 I feel my future is hopeless and will only get worse.

3. Past Failure
   0 I do not feel like a failure.
   1 I have failed more than I should have.
   2 As I look back, I see a lot of failures.
   3 I feel I am a total failure as a person.

4. Loss of Pleasure
   0 I get as much pleasure as I ever did from the things I enjoy.
   1 I don’t enjoy things as much as I used to.
   2 I get very little pleasure from the things I used to enjoy.
   3 I can’t get any pleasure from the things I used to enjoy.

5. Guilty Feelings
   0 I don’t feel particularly guilty.
   1 I feel guilty over many things I have done or should have done.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. Punishment Feelings
   0 I don’t feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. Self-Dislike
   0 I feel the same about myself as ever.
   1 I have lost confidence in myself.
   2 I am disappointed in myself.
   3 I dislike myself.

8. Self-Criticalness
   0 I don’t criticize or blame myself more than usual.
   1 I am more critical of myself than I used to be.
   2 I criticize myself for all of my faults.
   3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
   0 I don’t have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. Crying
    0 I don’t cry anymore than I used to.
    1 I cry more than I used to.
    2 I cry over every little thing.
    3 I feel like crying, but I can’t.
11. Agitation
0  I am no more restless or wound up than usual.
1  I feel more restless or wound up than usual.
2  I am so restless or agitated that it’s hard to stay still.
3  I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest
0  I have not lost interest in other people or activities.
1  I am less interested in other people or things than before.
2  I have lost most of my interest in other people or things.
3  It’s hard to get interested in anything.

13. Indecisiveness
0  I make decisions about as well as ever.
1  I find it more difficult to make decisions than usual.
2  I have much greater difficulty in making decisions than I used to.
3  I have trouble making any decisions.

14. Worthlessness
0  I do not feel I am worthless.
1  I don’t consider myself as worthwhile and useful as I used to.
2  I feel more worthless as compared to other people.
3  I feel utterly worthless.

15. Loss of Energy
0  I have as much energy as ever.
1  I have less energy than I used to have.
2  I don’t have enough energy to do very much.
3  I don’t have enough energy to do anything.

16. Changes in Sleeping Pattern
0  I have not experienced any change in my sleeping pattern.
1a  I sleep somewhat more than usual.
1b  I sleep somewhat less than usual.
2a  I sleep a lot more than usual.
2b  I sleep a lot less than usual.
3a  I sleep most of the day.
3b  I wake up 1–2 hours early and can’t get back to sleep.

17. Irritability
0  I am no more irritable than usual.
1  I am more irritable than usual.
2  I am much more irritable than usual.
3  I am irritable all the time.

18. Changes in Appetite
0  I have not experienced any change in my appetite.
1a  My appetite is somewhat less than usual.
1b  My appetite is somewhat greater than usual.
2a  My appetite is much less than before.
2b  My appetite is much greater than usual.
3a  I have no appetite at all.
3b  I crave food all the time.

19. Concentration Difficulty
0  I can concentrate as well as ever.
1  I can’t concentrate as well as usual.
2  It’s hard to keep my mind on anything for very long.
3  I find I can’t concentrate on anything.

20. Tiredness or Fatigue
0  I am no more tired or fatigued than usual.
1  I get more tired or fatigued more easily than usual.
2  I am too tired or fatigued to do a lot of the things I used to do.
3  I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex
0  I have not noticed any recent change in my interest in sex.
1  I am less interested in sex than I used to be.
2  I am much less interested in sex now.
3  I have lost interest in sex completely.
### Appendix D

#### UCLA Loneliness Scale

**R-UCLA Loneliness Scale**

Directions: Indicate how often you feel the way described in each of the following statements. Circle one number for each.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel in tune with the people around me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I lack companionship.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. There is no one I can turn to.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I do not feel alone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I feel part of a group of friends.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I have a lot in common with the people around me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I am no longer close to anyone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. My interests and ideas are not shared by those around me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I am an outgoing person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. There are people I feel close to.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. I feel left out.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. My social relationships are superficial.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. No one really knows me well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. I feel isolated from others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. I can find companionship when I want it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. There are people who really understand me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. I am unhappy being so withdrawn.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. People are around me but not with me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>19. There are people I can talk to.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. There are people I can turn to.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Appendix E

CONSENT TO PATRICIPATE IN A STUDY OF THE EFFECTIVENESS OF
A SUPPORT GROUP FOR MATURE ADULT WOMEN

Title of Research Study:
Utilizing A Small Group To Alleviate Symptoms Of Mild Depression In An Older Adult
Population At First Baptist Church Of Hendersonville, Tennessee

Project Director:
Roger D. Luther, M.A., M.R.E
Minister to Mature Adults
First Baptist Church of Hendersonville, TN
Office Phone: 615-447-1303

Purpose of this Research:
This study involves research in the effectiveness of a small group to alleviate symptoms
mild depression caused by grief and loneliness among a population of mature adult
widows. Additionally, an analysis of group components, and the overall perceived
effectiveness of the group by participants will yield vital information for formatting
future support groups. The duration of this project includes the initial meeting, eight
working sessions, and a termination session.

Procedures for this Research:
1. Participants will complete the Beck Depression Inventory II and the UCLA
Loneliness Scale before the second group meeting, and again during the last
group meeting.
2. Participants will engage in group discussions according to their individual levels of comfort.

3. Participants will rate components of each group for perceived effectiveness using a five-point Likert item scale.

**Potential Risks of Discomforts:**

This group is exclusively comprised of mature adult widows. Your situations bear similarity, yet everyone experiences loss and grief differently. You may initially be somewhat uncomfortable sharing your personal journey with the group. Hopefully, this will decrease as you become acquainted with the group members, and as trust is established. Individual group members always have total discretion concerning their level of participation in discussions. Someone will probably share their story and trigger an emotional response in you. Empathy can produce a range of emotional reactions. You may hear something that causes you to feel joyful or sad.

**Potential Benefits to You and Others:**

The potential benefits to you, and other group members, are support in your journey, emotional healing and a sense of well being. Further, you may learn more effective coping skills from studying the materials utilized in the group, and from interacting with other group participants. Lastly, your evaluation of group components will help to determine which components are most helpful. Your input will be utilized to fashion future support groups.
**Alternative Procedures:**

Group participants may want to consider engaging in individual counseling at some juncture. Counseling is advantageous to many who are dealing with grief issues. Please discuss counseling opportunities with the Project Director.

**Protection of Confidentiality:**

Confidentiality is essential for an effective group experience. The co-leaders of the group pledge to keep all participant information completely confidential. Each group member is ethically bound to keep all discussion confidential. The psychological examiner will keep individual participant self-reporting results confidential. Group composite self-report results will become part of the project report.

**Signatures:**

Please read the following statement:

I have been fully informed of the above-described project including the possible benefits and risks. I agree to participate in the group and give permission to release self-report composite results in the project report.

Please sign below.

<table>
<thead>
<tr>
<th>Signature of Participant</th>
<th>Name of Participant (Print)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________________</td>
<td>__________________________</td>
<td>____</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Person Obtaining Consent</th>
<th>Name of Person Obtaining Consent (Print)</th>
<th>Date</th>
</tr>
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Appendix F

Approved Doctor of Ministry Project Proposal

UTILIZING A SMALL GROUP TO ALLEVIATE SYMPTOMS OF MILD DEPRESSION IN AN OLDER ADULT POPULATION AT FIRST BAPTIST CHURCH OF HENDERSONVILLE, TENNESSEE

A DOCTOR OF MINISTRY PROJECT PROPOSAL SUBMITTED TO THE FACULTY OF THE TEMPLE BAPTIST SEMINARY IN CANDIDACY FOR THE DEGREE OF DOCTOR OF MINISTRY

BY

ROGER D. LUTHER

HENDERSONVILLE, TENNESSEE

SEPTEMBER 15, 2011
ABSTRACT

First Baptist Church of Hendersonville is a congregation of near nine thousand resident members, sixteen ministerial staff, and a host of ministries, providing excellent ministry services to the region. It is a congregation where every age group is acknowledged as a valuable contributor to the overall ministry. For thirteen hundred members who are age sixty-five and beyond, First Baptist is home. Many of this number are widows/widowers who live alone, going protracted lengths of time with little contact with the outside world. In a portion of this cohort symptoms of mild depression are noticeable. Few of them will seek professional counseling which is available on the church campus.

The purpose of this project is to evaluate the effects of a strategic small group in helping to alleviate symptoms of mild depression caused by grief and loneliness among an older adult church population. A reasonable hypothesis presumes that participation in a small grief share group will help individuals develop more effective mechanisms to cope with grief. Additionally, by regularly participating in a small homogeneous group, symptoms of loneliness and depression should be alleviated to some extent. Once these outcomes have been established, ongoing groups may be fashioned to address this identified need among the older adult population.
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CHAPTER I
INTRODUCTION

In the words of Robert E. Speer, “Christian faith is not the creation, it is the recognition, of the facts. By believing, we do not make anything true that was not true before. We simply bring ourselves into accord with what is and has always been the truth.”\(^1\) To recognize the facts, what is true, is the intent of this project. Just as in the Christian faith, the ultimate goal is to appropriately act upon those truths to be revealed in such a fashion that is beneficial to the church and brings honor to the Lord.

The church is comprised of all the diversity of the peoples of the world. The variety comes in an assortment of colors, languages, cultures, and ages. The collage is fascinating and functional. In most instances, however, things are best understood by looking at their individual parts, by a sorting out, by an investigation of a particular thing. The proposal at hand looks at a particular facet of the church, a particular population and cohort, the older adult.

Almost everyone wants to live long enough to become old, but almost no one wants to be old. Perhaps this is one reason for a lack of conversation regarding older adults in the context of the church. How older Christians fit in the local assembly is a matter of some debate. Churches are not always adept at helping older adults to manage

their health or maximize their potential. Some older adults who participate in church life are functionally depressed. Depression is “characterized by a depressed mood for most of the day, nearly every day, and may be accompanied by feelings of loneliness, sadness, or emptiness.”² Depressed Christians lack the capacity to adequately function in the life of the church. This proposal will visit this issue.

The purpose of the project is to evaluate the effects of a strategic small group in helping to alleviate symptoms of mild depression caused by grief and loneliness among an older adult church population. Concurrently, there are three ministry goals. The first goal is to educate ministry leaders. Older church members are struggling with issues of grief and depression. Church leaders will benefit from knowing if there are tools, strategic small groups in particular, which help their elderly population cope more effectively. Secondly, understanding what kind of small group is palatable to older adults and effective in addressing their problems is imperative. A homogeneous grief share group will be tested. The third goal is to discover what small group components are most beneficial in raising the affect of grieving, lonely persons. The information is invaluable for planning a comprehensive mature adult ministry.

Since this project director is currently the Minister to Mature Adults at First Baptist Church of Hendersonville, the research is of primary importance. The effects of loss, loneliness, grief, and depression are evident on a daily basis. Many older adults are grieving the loss of a spouse or significant friends. The findings of this project will help to develop a strategy for the Mature Adult ministry in this congregation. Additionally,

the project director desires to contribute to the field of mature adult ministry in a broad context. This material and subsequent findings will be made available to all who are likewise interested in serving mature adults.

**The Context**

First Baptist Church of Hendersonville

The church is a sixty-seven year old Southern Baptist Convention congregation of 8,785 resident members and is among the largest contributors to the Cooperative Program. The annual church budget is 9.5 million dollars. The congregation is located on a forty-acre campus. Buildings range in age from a four-year-old Family Ministry Center to a twenty-year-old Worship Center. Most of the educational space is ten to fifteen years old. The total square footage is approximately 330 thousand. The worship style is characterized as blended; however, one of the four morning services offers a more contemporary style.

The Senior Pastor and fifteen staff pastors comprise the ministerial staff. Ministerial staff tend to have long tenures at First Baptist. Thirty administrative assistant positions support the ministerial staff. Practically speaking, the church is elder-led, yet congregational affirmation is sought on major issues such as building projects, annual budget, and certain staff positions.

In January 2004, the position of Minister to Mature Adults was created due to the constant growth in that age bracket. The Minister to Mature Adults is responsible for the pastoral care and discipleship of members who are sixty-five years of age or older. There

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3First Baptist Church Hendersonville Automated Church System, (accessed September 6, 2011).
are 1,293 members who fall into this category. Of this number, 749 are both church and Sunday school members, and 484 are church only members. The Ventures ministry is the primary delivery system of ministry to the mature adult population, the church membership, and to the community at large. There are twelve ministry teams in the Ventures ministry regularly utilizing over 300 volunteers.

Twenty-one Sunday school classes accommodate this population. Additionally, weekday Bible studies, missions groups, fellowship and recreational opportunities are available. Ministry opportunities abound. The Ventures ministry is active in the local community, county, state, and beyond. Two mission trips each year, one to Canada, and one to West Virginia, are conducted exclusively by the Mature Adult segment of the congregation. A backpack ministry to nine county elementary schools delivers 280 backpacks weekly, over 2,800 pounds of food, to needy children and their families. Care teams minister to individuals in hospitals, nursing homes, hospice facilities, and the homebound. Older adults are seen as a vital part of the ministry of First Baptist.

The City of Hendersonville

Located in Sumner County adjacent to Metro Nashville, Hendersonville is a bedroom community of 48,773 residents. The city is situated on Old Hickory Lake, a recreational destination for many surrounding areas. Fishing boats and small yachts fill the lake each weekend. Three private country clubs and two public golf courses provide additional recreational activities. The Sumner County YMCA was built ten years ago,

and along with four larger church family ministry centers, gym space is ample. City parks with walking trails are easily available. Country music has significant ties to Hendersonville. The city is known as being the home of Johnny Cash, Roy Orbison, William Lee Golden, and Ricky Skaggs. Taylor Swift is the newest star to call Hendersonville home.

The city is mostly white, 92.9 percent. Over 10 percent, 4,125 persons, of the total population are sixty-five years of age or older. Women comprise 60 percent of that number. Another 10 percent, 4,064 persons, are between the ages of fifty-five and sixty-four years old. Most of the residents live in single family homes, and the occupancy rate is 97 percent. Hendersonville enjoys a good economy despite the current market downturn.

The Opportunity

With 1,293 members who are over sixty-five years of age, pastoral care situations are constant. Hospital and hospice visits are a part of everyday ministry life. Funerals are practically a weekly occurrence. Within this context, ministry opportunities abound. Although many older adults will not consider going for counseling when confronted with a debilitating emotional problem, they will sit with their pastor and chat, and they do.

The vast majority of pastoral chats concern dealing with loss, how to appropriately grieve, and how to carry on as a widow/widower. Coping with loneliness is a reoccurring theme among this age group. Depression is more significant than people are disposed to admit. Grief support groups could help many of these individuals; however, older adults tend to exclude themselves from open, therapeutic grief groups. Steven Rose characterized a small group as “ten to twenty people who share common purposes and
goals and meet on a regular basis for fellowship, relationship, interaction, and growth.”^5^ Although this describes several kinds of church groups, therapeutic overtones cause some to avoid participation. Many older women tend to avoid a group where much younger women participate, and older men are especially resistant to seeking help in a therapeutic group. To this generation, counseling, whether individual or group, is viewed as a weakness. Therefore, these depressed and lonely individuals tend to isolate themselves. The self-imposed isolation over time becomes self-perpetuating, thereby, causing more loneliness and depression.

**The Purpose**

The purpose of this project is to evaluate the effects of a strategic small group in helping to alleviate the symptoms of mild depression caused by grief and loneliness among an older adult population. First Baptist Church has an abundance of existing small groups with an assortment of primary purposes, but none focus on the emotional needs of an older adult population. The project director believes that a group may be effective in a secondary purpose, attenuating loneliness among this older adult population. This project will test the effectiveness of a strategically designed grief group, and the derivative benefit of a small group targeting widows and widowers who are mature adults. The primary focus of the group will be to help participants to effectively grieve the loss of their spouse, and secondarily, to assess the extent to which loneliness and symptoms of depression are alleviated. These questions, when answered, can help to

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fashion an ongoing ministry to this target population.

When the mature adult population of First Baptist is functioning well, hundreds of volunteers are set free to do the work of the ministry. When people are depressed, they do not function well. The health of the entire congregation is improved when there are high functioning older adults.
CHAPTER 2

LITERATURE REVIEW

Introduction to Biblical-Theological Review

When David penned the words, “I have been young and now I am old,” he was matter-of-fact.¹ The declaration was not particularly a testimony of lament but simply a statement of the obvious nature of change in the lives of humans. Aging happens, and the great king was not exempt from the experience. Some questions, however naturally arise, for instance, “When exactly does one become old?” The answer may be relative due to the changing realities of societies, but attempts are nevertheless made to quantify the process. A large number of individuals would agree, particularly the very young, that the onset of old age begins between sixty and sixty-five. The next twenty years being called “young old age,” and only past eighty-five are people the “oldest old.”²

Another question concerns the consequences of the process itself: “What can one reasonably expect to happen in old age?” Gary Collins in Christian Counseling suggests, “As we get older our bodies run down, but some bodies decline sooner and more quickly than others.”³ The picture becomes bleaker as he further lists problems associated with

¹Ps. 37:25. (All Biblical References are from the Holman Christian Standard Bible.)


³Ibid., 216.
aging grouped in the categories of mental, economic, and spiritual issues. Although he is indeed factual, both the condition and the prognosis appear to be quite poor. In this light therefore, an open and honest review of the aging process begs attention. A biblical theology in regard to aging, the adverse consequences of the aging process, and the potential for help in attenuating those consequences will be presented in this chapter.

**Aging in a Scriptural Context**

Solomon says in Ecclesiastes 12:1, “So remember your Creator in the days of your youth: before the days of adversity come, and the years approach when you will say, ‘I have no pleasure in them.’” Gary Collins quotes G. Stanley Hall as remarking about this passage “This is the most pessimistic description of old age ever written, but it also is realistic.”4 The reality of aging is clearly seen, from a particular perspective, in Ecclesiastes 12. Words and phrases like “before the sun and light are darkened, see dimly, while the sound of the mill fades, all the daughters of song grow faint, and mourners will walk around in the street” cannot be mistaken for an omen of good outcomes. Conversely, not all aspects of aging are negative and elicit a depressed response. There exist certain passages that are encouraging and uplifting. The psalmist in Psalm 92:14 says, “They will still bear fruit in old age, healthy and green.” One may rightly anticipate satisfying experiences in old age. Gary McIntosh in *One Church Four Generations* said “people have done their greatest work in old age.”5 Unfortunately true,

4Collins, 213.

5Gary L. McIntosh, *One Church Four Generations: Understanding and Reaching All Ages in Your Church* (Grand Rapids: Baker, 2002), 47.
however, is the fact that the latter years of the aging process provide fertile ground for all sorts of ailments and frailty associated with decline. Moses, in Genesis 48:10, reveals the reality, “Now Jacob’s eyesight was poor because of old age; he could hardly see.”

Although no two people experience exactly the same phenomenon, most people within a cohort have related experiences. McIntosh suggests that as a generation moves through time together, they experience similar events. This often results in the cohort adopting similar ways of thinking and feeling. 6 Although this is sometimes the basis of making generalizations and forming stereotypes, these similar tendencies provide a way to examine the characteristics of groups of people and learn from them. For instance, regarding the now seventy to eighty-year olds one may say, “They do things because they believe it is right to do them.” 7 Thus, through a generalization an accurate picture of a group is understood. Similarly, a generalization regarding old age may be made. A reasonable assumption is that many older adults have similar experiences. David gives insight in Psalm 39:5 into what may be the generally accepted reality of growing old, “You, indeed, have made my days short in length, and my life span as nothing in Your sight. Yes, every mortal man is only a vapor.”

In summary, everyone alive is aging. Growing older is inevitable. Not all aspects of aging are negative all of the time. For people of faith especially, satisfaction can be found in the later years of life. Older people can “bear fruit.” Many experiences in later life are, however, laced with the bitter taste of decline, and this decline takes the form of physical, mental, emotional, and sometimes spiritual pathology.

6 McIntosh, 30.

7 Ibid., 39.
Age Related Loneliness

For the sake of brevity in argumentation, consider it stipulated that the plan of God for the human race is moral (right) and ideal (good). As Creator, the design and operating capacity of humans is fully known by Him. He understands us. In that light, Genesis 2:18, “Then the Lord God said, ‘It is not good for the man to be alone. I will make a helper who is like him’” is a statement of how best to function at high volume. That relationship served Adam well and allowed him to better operate in context, both with Eve and God. In his book *Soulcraft*, Douglas Webster writes, “God designed us in such a way that the measure of our communion with Him is reflected in the depth of our relationships with others.”

Cloud and Townsend go a step further saying that “Loving God and others is the end result and purpose of basically any good activity.” Significant relationships are important in the lives of humans.

Through the process of aging and eventually death, relationships are broken. Larry Crabb suggests that the consequences of these broken relationships are severe, “We were designed to connect with others: Connecting is life. Loneliness is the ultimate horror.” This reasoning is consistent with Psalm 25:16, “Turn to me and be gracious to me, for I am alone and afflicted.” Negative consequences are associated with being lonely.

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Gary Collins describes it this way:

Loneliness is the painful awareness that we lack close and meaningful contact with others. It involves a feeling of inner emptiness, isolation, and intense longing. Frequently there are feelings of sadness, discouragement, restlessness, and anxiety, accompanied by a longing to be wanted and needed by at least one other human being.\textsuperscript{11}

Regardless of the reasons for being lonely the outcomes are quite negative. Being lonely is contrary to the original plan for humans. Adam and Eve were never alone or lonely, but that is not totally accurate. Eventually one of them died.

Collins notes, “Friends and relatives, including one’s spouse, often die and leave surviving older people without peers to bolster morale.”\textsuperscript{12} Through no particular fault of an older person, no selfish demands, no unrealistic expectations, relationships are broken. People grow old and die leaving someone alone and lonely. The one left behind may feel as if they no longer fit. They may “lack a sense of belonging, feel isolated, lonely, unwanted, and often unable to trust.”\textsuperscript{13}

Loneliness can foster other related emotional difficulties. For instance, the fear of developing new relationships may occur. Charles Stanley suggests that “God never intended that we live in fear that keeps us from seeking deeper relationship with Him or that keeps us from going about normal daily life or fulfilling the responsibilities we have

\textsuperscript{11} Collins, 93.
\textsuperscript{12} Ibid., 217.
\textsuperscript{13} Gary R. Collins, \textit{The Biblical Basis of Christian Counseling for People Helpers: Relating the Basis Teaching of Scripture to People’s Problems} (Colorado Springs: Navpress, 1993), 198.
Fear can render the older person helpless. Loneliness that leads to fear can in turn cause isolation that increases loneliness. The problem may become cyclical and feed on itself. Carter notes, “Many people who are lonely passively sit around waiting for someone to come along or something to happen that will bring them out of their loneliness.” When rescue does not occur and time alone does not heal the longings of the heart, older people may “close their heart to others, and feel empty and meaningless.”

To summarize, by the design of God, humans are meant for relationship with one another. Humans function more fully in relationship. Older adults sometimes find themselves alone through no fault of their own. People whom they love die. Loneliness can be debilitating. Pathological thinking and behaving may be the result of prolonged loneliness.

**Church Groups Attenuate the Effects of Loneliness**

In Ecclesiastes 4:9-10 the Preacher states, “Two are better than one because they have a good reward for their efforts. For if either falls, his companion can lift him up; but pity the one who falls without another to lift him up.” The fallen are well served by being in a relationship with a trusted companion. Inherent in the nature of

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15 Crabb, 54.


relationships is reciprocity. Both benefit from the relationship. This kind of relationship may be found in a solitary individual or a group of likeminded individuals. The Church of Jesus Christ is a group of likeminded individuals who have covenanted together.

Collins further explains, “The role of the Church is that of a community of believers who are dedicated to encouraging and building up one another. In a society where there is widespread isolation, loneliness, …and broken relationships, people need the kind of community that is found only in the Church.”18 The church has the capacity to help alleviate the negative effects of loneliness in the lives of older adults. Due to the highly relational nature of the local church, meaningful friendships are a natural by product. In the book of Romans one may clearly see the obligation Christians have to one another. For instance, in chapter 12 “show family affection,” chapter 13 “love one another,” chapter 14 “build up one another,” chapter 15 “agree with one another,” and “accept one another,” and finally in chapter 16 “greet one another.” Frank Viola in *Reimagining Church* says of the early church, “‘one another’ is its dominant feature, mutual edification its primary goal.”19 In this context loneliness in an individual would be combated by the mutuality of the body life of the church members.

When John MacArthur spoke of Jesus utilization of the disciples, he noted that “there was no plan B if they failed.”20 Various congregations may or may not attend to

18 Collins, *The Biblical Basis of Christian Counseling for People Helpers: Relating the Basis Teaching of Scripture to People’s Problems*, 204.


the emotional needs of their membership effectively. However, when individual members are ministered to and nurtured, the entire congregation is made stronger. David Augsburger notes that the church must “look for opportunities of affirming and encouraging, of helping release others to be all they can be in Christ. Concern for mutual fulfillment, joint opportunities for service and shared meaningful work is the real goal.”

That he is suggesting assisting a weaker, more vulnerable individual is clear. Older adults who are lonely, isolated, afraid, and depressed particularly need the help of a loving church community. Gary Collins says, “Get the congregation in contact with the elderly and involved in helping; plan programs for seniors, create opportunities for older people to get involved in useful service.” Again, this admonition is seen as both a responsibility and an opportunity. When congregations appropriately love their older members the whole body becomes healthier.

When the older adult who feels depressed due to loneliness engages in a self-imposed isolation it can be difficult for them to reconnect with society in general. The world may seem too big or frightening. They may have a sense on not belonging anywhere. However, “since the Church is the place where older adult Christians already belong they can reconnect with a community.” Focusing on the fellowship of the local assembly of believers helps the lonely person to forego less appropriate venues to assuage his or her loneliness. Henri Nouwen thinks, “the problem with modern living is

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23Ibid., 198
that we are too busy looking for affirmation in the wrong places.”24 By reconnecting with the local church, the older adult may find that the longings of their heart are met. In Inside Out, Larry Crabb calls these longings “critical longings.”25 These longings are met through high quality relationships with friends who will be there when we need them.

In summary, Christian companions help to make life livable. A major theme of the church of Jesus Christ is to “love one another.” Older adults who suffer from depression due to the effects of loneliness comprise a segment of many congregations. The entire congregation becomes stronger as lonely older adults are loved, encouraged, and nurtured to a place of renewed ministry.

Introduction to General Literature Review

In his book Who Moved My Cheese?, Spencer Johnson uses a parable to reveal truths about the changing nature of life. In this parable “cheese” is a metaphor for the things most desirable in life, such as a good job, loving relationships, health, etc., and it becomes clear rather quickly that change is inevitable, can be anticipated, and must be dealt with by everyone. When he urges people to see the “handwriting on the wall,” he says, “Adapt to change quickly (The quicker you let go of old cheese, the sooner you can enjoy new cheese).”26 Change may appear to accelerate in old age. Life altering events can happen rapidly, potentially leaving the older adult at a loss for effective mechanisms

for coping. This chapter will explore a profile of older adults, the problem of depression caused by loneliness, and a potential aid in combating loneliness in an older adult population.

**A Profile of Older Americans: 2008**

The United States Department of Human Services, Department on Aging, collects and compiles information on older Americans each year. The following statistics give an accurate picture of aging in America.

- The older population (sixty-five years of age or older) numbered 37.9 million in 2007, an increase of 3.8 million or 11.2 percent since 1997.
- Over one in every eight, or 12.6 percent, of the population is an older American.
- Persons reaching age sixty-five have an average life expectancy of an additional nineteen years.
- About thirty percent of noninstitutionalized older persons live alone.
- Half of older women (49 percent) age seventy-five and older live alone.
- The population sixty-five years old and over will increase to forty million by 2010, and 6.6 million by 2020.
- The eighty-five years of age or older population is projected to increase from 4.2 million in 2000 to 5.7 million in 2010 (a 36 percent increase for that decade).
- The median income of older persons in 2007 was 24,323 dollars for males and 14,021 dollars for females.
- Social Security constituted ninety percent or more of the income received by thirty-two percent of all Social Security beneficiaries.
About 3.6 million elderly persons (9.7 percent) were below the poverty level in 2007.²⁷

These statistics paint a picture that looks dramatically different from generations past. America is entering a period when there will be more older adults than at any point in history. They will change the demographics of the country and the way old age is viewed. As older Americans live longer and healthier lives, many are planning to work longer than their counterparts in previous generations. According to a recent survey, 80 percent of baby boomers expect to work past traditional retirement age.²⁸ Some may do so because they enjoy physical and mental benefits, while some may need the additional income to remain financially secure. Regardless of the reasons for staying at their jobs, older adults are changing the way the nation views retirement. There is no longer a one-size-fits-all way of looking at retirement or aging in general.

Lonely and Depressed

In many instances what an individual does is dictated by what he or she thinks they should do. Societal forces shape lives to some extent. This is true of some of the negative aspects of aging. Social policies and practices, societal expectations and norms shape how older adults live out their lives. Learned helplessness is one such negative aspect of aging that has roots in social practices. When government policy makes people dependent, it often leads to their disengagement with society at large. Dependency and


disengagement frequently facilitate depression in older adults. Depressed mood associated with isolation is a significant factor in health issues among older adults. It is a powerful “predictor of poor health.”

Social policy and societal expectation are not the only factors contributing to depression among this population. Many life-altering events such as the death of a spouse, declining mobility, and infrequent contact with family result in significant bouts with depression. These events are closely associated with loneliness which breeds both illness and early death. Among people whose relationships with others are fewer and weaker, “the risk of death is two to four times as great,” irrespective of any other personal factor.

About 15 percent of older people in the community and 25 percent of nursing home residents suffer from depression. Of all the possible contributing factors to this rate, having functional limitations in physical health is the strongest predictor of major depression. The odds of becoming depressed are twice as great among older adults who are experiencing moderate physical limitations. Sometimes it is not the limitation itself that is the source of depression, but the issues associated with physical decline.


32 Ibid., 156.


34 Ibid., 258.
Having to sell a house to pay for hospital expenses can produce psychological trauma in the elderly person. They may become depressed due to the belief that they simply have no legitimate choice. They feel that they have no control over their lives. Additionally, the physically frail are particularly vulnerable to feelings of loneliness because they often spend long periods of time alone. With no particular reason to go out of their homes, they tend to become increasingly isolated. Isolation, whether self imposed or due to inability to be mobile, is a common theme among older adults. In one recent study as many as 75 percent of the sample group had fewer than twenty-one direct, face to face, contacts a week qualifying as “socially isolated.”

The Alliance for Aging Research published these facts about depression among older adults:

- Depression is a chronic disease with a very high likelihood of recurrence.
- Six million elderly suffer from some sort of depression.
- Clinical depression can often accompany long-term illnesses.
- The number of suicides each year is greater than the number of deaths from homicide.

36 Robert A. Baron, Psychology (Boston: Allyn and Bacon, 2001), 551.
38 Ibid., 2
In the elderly population, men are nearly six times more likely than women to commit suicide.

Less severe forms of depression are also common among the elderly and can be as debilitating as Major Depressive Disorder. Often times depression goes undetected among the older adult population. Because there is reduced contact with the outside world and with families who know them well, the problem is never addressed. Even when in contact with a primary care physician, studies show that less than one-half of depressed elderly are ever diagnosed. Some speculate that primary care physicians are not trained to look for symptoms in their older patients. Another factor that may contribute to low rates of diagnosis and treatment of depression among this population is the misconception that depression is a normal part of aging. According to Lea Ann Browning McNee, senior vice president of public affairs and community development at the National Mental Health Association, “no one has to live with depression.” Unfortunately, the elderly are more likely to try to deal with depression alone rather than consult a mental health professional. This “aloneness often breeds loneliness,” further contributing to the problem.

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41 Ibid., 2.

42 Ibid., 1.

To summarize, sometimes societal forces shape negative practices among older adults leading to depression. Life altering events contribute heavily to negative change in the lives of older adults. Functional limitations in the physical condition of older adults are the most profound cause of their depression. Frequently depression goes undiagnosed in the elderly population due to lack of awareness of primary care physicians. Perhaps depression is undiagnosed because of the myth that depression is normal among this population of older adults.

**Socialization Aids in Combating Loneliness**

Agencies who work with the elderly realize that isolation and loneliness that leads families encourage their loved ones to “share their concerns, with a health care professional, faith leader, or other resource person.” The problem must be addressed within the context of community by people who represent various facets of the older person’s life. The problem of isolation cannot be treated in isolation. In fact “social support has a direct positive effect on health. It can buffer or reduce some of the health related effects of aging.” One does not outgrow the need for others. The “life-giving effect of close social relations holds throughout the life course.”

One study of elderly patients hospitalized with major depression disorder revealed that “long term marriages are viewed as positive.” Patients recovered more quickly and

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44 Alliance for Aging Research, “Detecting Depression Before It’s Too Late.”

45 Rowe, 153.

46 Ibid., 156.

were released from the hospitals earlier than their unmarried counterparts. When an individual has no spouse to return home to, one must have “close friendships or confidants.” Confidants prove to be extremely important in maintaining high morale which is closely associated with a general state of happiness. A study published by Age and Ageing looked at the persistence of depression in older people. It concluded that a “belief in powerful others” has a positive effect in recovery and that “a low belief in powerful others predicted depression persistence.” Having a support network proved to be a significant factor in their recovery. Similarly, a study of individuals over one hundred years of age showed that “the most well preserved people are those who remain intellectually stimulated, those who still maintain satisfactory social relationships and, in particular, can count on the help of the family or others.” When asked to identify strategies to help combat loneliness and depression, older people themselves suggested that the best intervention was an “enhanced social network promoting a sense of neighborliness and community.” Maintaining “satisfactory social relationships” has even been recognized as a predictor of long life.

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48 Guy Lefrancois, The Lifespan (Belmont: Wadsworth, 1993), 635.


51 Victor, Bowling, Bond, and Scamber.

52 Buono, Urciuoli, and De Leo, 212.
Participation in religious faith, as a particular form of socialization, is seen as important to some of the most elderly. Those interviewed found “greater solace in faith than less elderly groups.” Many believe that religious involvement is a contributing factor to the longevity among this population. Religious practices play a significant role in the lives of older Americans “where approximately one-half of the older population attends religious services at least weekly.” Statistics suggest a strong positive correlation between longevity and religious involvement and practice. This makes the “neglect of religion and spirituality by gerontologists all the more surprising.” The statistics, although not having made an impact on gerontologists at large, have not gone unnoticed by everyone.

As reported by the Centers for Disease Control and Prevention, the City of Seattle’s Aging and Disability Services and Senior Services of Seattle are cosponsors of the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS). The program “aims to reduce minor depression and resulting disability among older adults by teaching them depression management techniques.” This public program will encourage participants to “meet recommended levels of social and physical activity by using

53 Buono, Urciuoli, and De Leo, 212.


55 Ibid., 318.

community settings, such as senior centers, community centers, and faith communities.”

Similarly, the United States National Institutes of Health, National Institute on Aging Council Minutes from May 1996 reveal federal funding for the Behavioral and Social Research Program. A significant part of the research will be conducted in the area of “health and religion.”

In summary, the problems of loneliness and depression among the elderly population are best addressed in a multidisciplinary social context. Hospitalized patients who have a strong social network, or at least one confidant, recovered more quickly than their counterparts who were alone. There is a strong correlation between health and religious practice. The government, on multiple levels, is involved in studying the relationship between health and religion.

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57 Prevention Research Centers.

CHAPTER 3
DESCRIPTION OF FIELD PROJECT

Project Overview

This purpose of this project is to discover the effects of a strategic small group in helping to alleviate the symptoms of mild depression caused by grief and loneliness among an older adult population at First Baptist Church in Hendersonville, Tennessee. During the course of the project the following three questions will be answered: How does participation in a strategic small group help to alleviate symptoms of mild depression caused by grief and loneliness? What group components are most beneficial in raising the affect of grieving, lonely persons? Why, or why not, would members continue group participation past the treatment time frame?

The strategic small group will utilize Grief Share, a published curriculum widely distributed for small group therapy. Video sessions include: Living with Grief, The Effects of Grief, When Your Spouse Dies, God’s Prescription for Grief, and several other related topics. In addition to this primary teaching tool, group meetings will include a module of topic related Bible study and prayer presented in the manner of a devotional time. Finally, a time for unstructured fellowship and personal interaction will be provided and encouraged.

Group participants will be selected and invited from a list of Mature Adults whose spouses have died within the past two years, and who currently live alone. A
homogeneous group is desired for this project. Persons who closely, yet do not exactly, match this criteria will be accepted on a case by case basis. A preliminary search has identified fifty possible participants in the target category. A minimum number of eight group participants and a maximum number of twelve is the goal.

The group will meet weekly on Tuesday morning for two hours. There will be ten scheduled meetings, although group members may choose to meet together outside the prescribed parameters of the group. Sessions will occur in the conference room at the Babb Center, the church counseling ministry, located on the church campus.

A reduction in the reported feelings of depressed mood originating from grief and loneliness is the anticipated outcome. If this hypothesis is substantiated by the project, a tool to help depressed older adults will have been identified. Additionally, components of the group that are particularly helpful will be discovered.

**Instruments of Measurement**

Two instruments have been selected to measure the prevailing depressed mood caused by grief and loneliness in the target older adult population. Both instruments are easily administered and relatively short, yet have a well established validity. The instruments are: The UCLA Loneliness Scale, and the Beck Depression Inventory II. These instruments are not cost prohibitive and may be administered and interpreted by persons with a counseling psychology background.

The UCLA Loneliness Scale consists of ten questions with the participants choosing one of four possible responses. It was developed to measure subjective feelings of loneliness. It is user-friendly with an elderly population. The anticipated administration time is five minutes.
The Beck Depression Inventory II consists of twenty-one groups of statements with four possible responses for each item. This is probably the most widely utilized instrument for detecting depression in the United States. It is user friendly with populations from adolescence throughout the lifespan. The anticipated administration time is ten minutes.

Instruments will be administered and interpreted by a staff psychotherapist from the Babb Center, the counseling center at First Baptist Church of Hendersonville. A pre-test and post-test scenario will be utilized.

In addition to these instruments, each participant will be asked to complete a simple evaluation of the group experience addressing five questions. Do you feel better than you did before starting the group? What was the most beneficial component of the group? What would you change? Would you consider continuing to meet as a group past the treatment guidelines? Would you recommend a similar group to a friend?

At the culmination of the project a counseling appointment with this researcher will be scheduled for each participant. The primary focus of the appointment will be to debrief the participant. Should any significant findings result from the pre-test/post-test, the group sessions, or during the debriefing session, subsequent counseling sessions will be made available to the participant.

This researcher understands that there is a distinct possibility of the Hawthorne Effect in this project. A control group of five individuals who meet the original criteria will be established. In addition to the pretest they will be administered a post-test with no treatment during the ten-week project period. Their scores will be compared to the test group to establish the validity of the project.
Project Outline

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A. Participant Survey

B. Participant Survey Result
Schedule

Possible project participants will be identified by utilizing the Automated Church System of First Baptist Church, Hendersonville during the month of August 2011. The Doctor of Ministry Project Proposal will be submitted for approval by September 15, 2011. Possible participants will be contacted between September 15 and September 29, 2011 while awaiting the final approval of the project proposal.

Therapeutic group sessions will begin on Tuesday, October 4, 2011 and run for ten consecutive weeks ending with the group on December 6, 2011. Post-tests will be administered on the last day of group meetings. Debriefing sessions will be conducted during the next two weeks and will conclude by December 20, 2011.

A preliminary draft of the project will be submitted by January 15, 2012. The final revision of the Doctor of Ministry Project Report will be submitted by March 15, 2012.
CONCLUSION

According to Britannica, research involves investigation, experimentation, interpretation, and application. As an investigator this project director seeks to accomplish each of these aspects by fully implementing this project. As a researcher this project director desires to make discoveries in the area of Mature Adult ministry that will contribute to the well being of older adults within the body of Christ.

Does participation in a strategic small group help to alleviate symptoms of mild depression caused by grief and loneliness? The anticipated answer to this question is in the affirmative. The development of better coping skills should positively impact the affect of a grieving person. Meaningful interaction with others would logically help people to be less lonely. However, individuals may still feel lonely while surrounded by others. The outcome is not yet certain.

What component of the group offers the most help in alleviating symptoms of mild depression caused by grief and loneliness? How well do the specialized lessons on coping with grief assist the older adult to fully engage in life rather than simply exist? Is the Bible study and devotional module therapeutically effective? Does the socialization aspect of a strategic small group have a significant impact on feelings of loneliness?

Will participants want to continue the group past the project guidelines? What can group leaders learn from their feedback? Ministry leaders should know what factors most positively contribute to the spiritual, emotional, and social health of older adults. They should be aware of how strategic small groups contribute to health and a sense of well being. By fully implementing this research some, perhaps all, of these questions will be answered.
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