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A theoretical analysis of a bible study group of elderly persons coping with change: Implications contributing to a conceptual model of pastoral care in the institutional geriatric church

Marion H. Arnold
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A THEORETICAL ANALYSIS OF A BIBLE STUDY GROUP OF ELDERLY PERSONS COPING WITH CHANGE: IMPLICATIONS CONTRIBUTING TO A CONCEPTUAL MODEL OF PASTORAL CARE IN THE INSTITUTIONAL GERIATRIC CHURCH

by

MARION H. ARNOLD

A DISSERTATION

Presented in Partial Fulfillment of Requirements for the Degree of Doctor of Ministry in the Department of Psychology and Pastoral Care, The Interdenominational Theological Center

Atlanta, Georgia

1983
ABSTRACT

A THEORETICAL ANALYSIS OF A BIBLE STUDY GROUP OF ELDERLY PERSONS COPING WITH CHANGE: IMPLICATIONS CONTRIBUTING TO A CONCEPTUAL MODEL OF PASTORAL CARE IN THE INSTITUTIONAL GERIATRIC CHURCH

by
Marion H. Arnold
May 1983
172 Pages

Purpose

The purpose of this dissertation is to construct a model of pastoral care that will inform through implications, the conceptualization of the nature, purpose, and meaning of pastoral care to geriatric persons residing in mental hospitals. The purpose is also to show the relationship of six of the latest theories on aging and their use in the model to the life quality of the above mentioned geriatric persons. The study examines the usefulness of theories of aging for their relevancy in developing a model of pastoral care for the Institutional Geriatric Church, especially for those elderly persons coping with change of environment and/or relocation. Pastoral care is concerned with a liberating ministry, to include the total caring resources of this community of estrangement of the geriatric person, so that he/she can experience the grace of God through the release from fear of a change of environment and an adjustment to the move. This liberating ministry further is concerned with the patient's positive growth to God, acquisition and/or strengthening of a basic integrity of the life they have lived, a religious commitment to the present and the future as well as the building and
maintenance of love for self, for peers, and for other members of this church. The liberating ministry, succinctly, is a recognition and release of potential in geriatric persons in spite of their limitations. The intent is to draw from behavioral science principles and the Liberation Ministry concepts to construct the model.

Methods and Procedures

There are two methodologies employed in the dissertation: the exploratory research method (such as the research of the selected literature that is available on the subject to stimulate insights from a behavioral science reference) and the theological method of correlation for developing the theological nature of the study. Through the use of the correlational method, data is analyzed by way of application of a theological perspective and several behavioral science perspectives; more specifically, the model of pastoral care was developed by examining what the differing frames of reference had to say to each other analogously as a result of their analysis of common data.

Results

Through the study, it was possible to construct a model through which was conceptualized the answer to the question of how the Liberation Ministry could best serve the needs of the estranged geriatric person in this church.

Conclusions

The model for pastoral care in the Institutional Geriatric Church represents theory building. It is intended as an example of what is possible and each church must design its own model of pastoral care based upon its own peculiar needs.
ACKNOWLEDGEMENTS

This author is very deeply indebted to the many professors, authors, residents and staff of Central State Hospital, family and friends whose ideas have been a source of personal help, inspiration and meditation. It is impossible to name them all because they are so great in number. However, it is salient that certain individuals are named here because of their particularly thoughtful suggestions, criticisms and directing efforts in the preparation of this document. The following professors were of inestimable assistance to this writer: Dr. Edward P. Wimberly whose concept of pastoral care appears herein and whose constant recommendations from chapter to chapter concerning scholastic achievement towards meeting the demands of acceptance of originality in the writer's theological conceptions; Dr. Jonathan Jackson for his thorough, entrenching questions necessary for the completion of this work, the answers of which are embodied within and throughout this paper; and Dr. Anne E. S. Wimberly whose guidance in proper literature form and review offered an opportunity for a prolific growth in writing skills, the accomplishment of which served as an important factor in the faculty acceptance of this dissertation. Not only this, but she edited the entire works of this dissertation.

Several friends went beyond the call of duty in typing the manuscript and in giving needed encouragement throughout the preparation stage of the study. These persons include:

vii
Mrs. Louise Sweat who typed the entire manuscript from beginning to end of this study, Dr. E. F. Stincer, Mrs. Faye Brown, Mrs. Elizabeth Littlejohn, Mrs. Barbara Holton, and Mrs. Loretta Barnes. My mother-in-law, sons and daughter, sisters and brother also kept constant vigil, counting my personal liberation as their own.

Most of all, it shall never be possible to express the deep and enveloping gratitude and love that shall remain for the abiding care, concern, assistance, and patience shown by my wife, Theresa.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCEPTANCE</td>
<td>iii</td>
</tr>
<tr>
<td>COPYING AGREEMENT</td>
<td>iv</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>v</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>vii</td>
</tr>
<tr>
<td>Chapter</td>
<td></td>
</tr>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>A. The Problem of the Dissertation</td>
<td>1</td>
</tr>
<tr>
<td>B. The Significance of the Study</td>
<td>1</td>
</tr>
<tr>
<td>C. Definitions</td>
<td>6</td>
</tr>
<tr>
<td>D. Theological Norms</td>
<td>11</td>
</tr>
<tr>
<td>E. Methods of the Dissertation</td>
<td>18</td>
</tr>
<tr>
<td>F. Review of the Literature</td>
<td>22</td>
</tr>
<tr>
<td>G. Limitations of the Study</td>
<td>26</td>
</tr>
<tr>
<td>II. THEORIES OF AGING: QUESTIONS AND IMPLICATIONS</td>
<td>29</td>
</tr>
<tr>
<td>A. Introduction</td>
<td>29</td>
</tr>
<tr>
<td>1. Theories of Aging</td>
<td>30</td>
</tr>
<tr>
<td>B. Activity Theory of Aging</td>
<td>31</td>
</tr>
<tr>
<td>C. Disengagement Theory of Aging</td>
<td>32</td>
</tr>
<tr>
<td>D. Biological Theories of Aging</td>
<td>35</td>
</tr>
<tr>
<td>E. Environmental Theories on Aging</td>
<td>37</td>
</tr>
<tr>
<td>F. Developmental Theories of Aging</td>
<td>40</td>
</tr>
<tr>
<td>Chapter</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
<td>------</td>
</tr>
<tr>
<td>G. Continuity Theories of Aging</td>
<td>42</td>
</tr>
<tr>
<td>1. Continuities of Personality in Relation to Continuities of Coping Stances into Old Age</td>
<td>45</td>
</tr>
<tr>
<td>a. Stress and Coping in Late Life</td>
<td>46</td>
</tr>
<tr>
<td>H. Summary</td>
<td>61</td>
</tr>
<tr>
<td>III. THE HOSPITAL SETTING AND PRESENTATION OF THE DATA</td>
<td>63</td>
</tr>
<tr>
<td>A. Introduction</td>
<td>63</td>
</tr>
<tr>
<td>B. A Brief History of Central State Hospital</td>
<td>63</td>
</tr>
<tr>
<td>C. The Geriatric Division of Central State Hospital</td>
<td>65</td>
</tr>
<tr>
<td>D. Case Studies of Members of the Bible Study Group</td>
<td>69</td>
</tr>
<tr>
<td>E. A Systematic Report of Each Session of the Bible Study Group</td>
<td>84</td>
</tr>
<tr>
<td>F. Summary</td>
<td>98</td>
</tr>
<tr>
<td>IV. A THEORETICAL ANALYSIS AND EVALUATION OF THE DATA</td>
<td>99</td>
</tr>
<tr>
<td>A. Introduction</td>
<td>99</td>
</tr>
<tr>
<td>B. Reactions and Behavior of Cases Number One and Two in the Bible Study Class: A Side by Side Theoretical Analysis</td>
<td>100</td>
</tr>
<tr>
<td>C. Reactions and Behavior of Cases Number Three and Four in the Bible Study Class: A Side by Side Theoretical Analysis</td>
<td>108</td>
</tr>
<tr>
<td>D. Final Summary</td>
<td>116</td>
</tr>
<tr>
<td>E. The Writer's Theoretical Evaluation of the Bible Study Class</td>
<td>121</td>
</tr>
<tr>
<td>Chapter</td>
<td>Page</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>F. The Writer's Theoretical Evaluation of a Bible Study Group of Elderly Persons Coping with Change</td>
<td>125</td>
</tr>
<tr>
<td>V. A NORMATIVE THEOLOGICAL ANALYSIS AND EVALUATION OF THE DATA</td>
<td>128</td>
</tr>
<tr>
<td>A. Introduction</td>
<td>128</td>
</tr>
<tr>
<td>B. The Reactions and Behavior of Case Number One During the Bible Study Class Sessions</td>
<td>129</td>
</tr>
<tr>
<td>C. The Reactions and Behavior of Case Number Two During the Bible Study Class Sessions</td>
<td>133</td>
</tr>
<tr>
<td>D. The Reactions and Behavior of Case Number Three During the Bible Study Class Sessions</td>
<td>137</td>
</tr>
<tr>
<td>E. The Reactions and Behavior of Case Number Four During the Bible Study Class Sessions</td>
<td>140</td>
</tr>
<tr>
<td>F. Summary</td>
<td>144</td>
</tr>
<tr>
<td>VI. A PASTORAL CARE MODEL FOR THE INSTITUTIONAL GERIATRIC CHURCH</td>
<td>145</td>
</tr>
<tr>
<td>A. Introduction</td>
<td>145</td>
</tr>
<tr>
<td>B. The Theological Method of Correlation</td>
<td>145</td>
</tr>
<tr>
<td>C. The Theological Norms of Geriatric Pastoral Care</td>
<td>145</td>
</tr>
<tr>
<td>D. The Theoretical Norms of Geriatric Pastoral Care</td>
<td>147</td>
</tr>
<tr>
<td>E. Geriatric Pastoral Care and Theories on Aging: Implications</td>
<td>149</td>
</tr>
<tr>
<td>F. Church Worship Services</td>
<td>154</td>
</tr>
<tr>
<td>G. Nurture</td>
<td>156</td>
</tr>
</tbody>
</table>
# Table of Contents

## Chapter H. Care ................................................................. 158

## I. Summary ................................................................. 159

## VII. CONCLUSIONS AND RECOMMENDATIONS ......................... 161

### A. Restatement of the Problem ........................................ 161

### B. A Summary of the Study Methods ................................. 162

### C. Limitations of the Methods and the Model ........................ 163

### D. Conclusions and Summary ........................................... 164

1. Conclusions about Life Quality Impacted with Education .......... 165

2. Conclusions about Continuity of Life Processes in Geriatric Persons 165

3. Conclusions about Geriatric Theology ............................... 165

4. Conclusions about the Community Aspect of Pastoral Care ........ 166

### E. Recommendations for Further Investigation ...................... 166

1. Evaluation ............................................................... 166

2. Description ............................................................ 167

3. Experimental .......................................................... 167

### F. Summary ............................................................... 167

BIBLIOGRAPHY ............................................................... 168
LIST OF ILLUSTRATIONS

Figure                                                                 Page
1. Diagram of Correlation ........................................ 151
2. A Model for Pastoral Care in the Institutional Geriatric Church ........ 153
CHAPTER I

INTRODUCTION

A. The Problem of the Dissertation

The purpose of the dissertation is to construct a model of pastoral care that will inform, through implications, the conceptualization of the nature, purpose and meaning of pastoral care to geriatric persons residing in institutions, more specifically those residing in mental hospitals. The purpose is also to show the relationship of some of the latest theories of aging and their use in the model to the life quality of the above-mentioned geriatric persons. The study will examine the usefulness of theories of aging for their relevancy in developing a model of pastoral care for the Institutional Church, especially for those elderly persons coping with change of environment and/or relocation.

B. The Significance of the Study

For several years there has been a growing concern among Gerontologists for developing a body of literature reflecting a variety of subjects with the hope of shedding some positive light on the gerontological experiences in America. In terms of the Institutional Church, much of the literature focuses upon theological and socio-anthropological
analysis and research while there is almost a total absence of literature focusing upon the pastoral care perspective in the Institutional Church. Consequently, there is a real need to begin to develop a body of literature and research on the Institutional Church reflecting the pastoral care perspective, especially where ministry to the geriatric society is concerned.

One motivation for undertaking this study is to make a contribution to laying a foundation for the development of literature focusing upon the pastoral care perspective in the Institutional Geriatric Church.

The specific motivation for developing a model of pastoral care for the Institutional Geriatric Church came from the writer's observations while participating as a clinical chaplain intern in the Clinical Pastoral Education program at Central State Hospital in Milledgeville, Georgia. The writer's job description called for the teaching of a previously organized and established Bible class to elderly persons for the purpose of furthering Christian Education. The writer discovered that a basic fear existed among the members of the class because of a planned movement from one building to another.

Fear is largely a reaction to the unknown. Anticipation, arising from imagination, is almost always worse than reality, particularly if the imagination is grossly distorted by false notions. All of us recall occasions when
actual bad news was a relief. Uncertainty usually conjures up evils far worse than reality.¹

There are no limits to the fantastic catastrophes which fear can create in the mind. Many mothers have experienced immense relief when little Johnnie is carried in with a sprained ankle, or even a broken arm, after being more than an hour overdue from school. When a situation is thoroughly understood and when there is something that we can do about it, it ceases to be so fearful. Knowledge dissipates enshrouding fear which hampers happiness similarly as radar enables us to "see" through the obscurity of fog, darkness, or storm.²

Moving is a crisis for young and old alike. According to Cowdry, the elderly person entering any new abode faces multitudinous unavoidable changes. Loss of familiar landmarks in an alien environment can mean the difference between a restful night's sleep and a nightmare of disorientation and incontinence.³ This problem of the elderly is a thrust of the presentation of the evaluation of an act of ministry (Bible Study) that the writer performed with elderly persons in crisis (precipitated by the threat and actuality of loss of familiar surroundings) as they moved from one building to another. As a matter of fact, the class started

²Ibid., p. 3.
three weeks before the move (consideration of anticipation which involves fear) and ended nine weeks after the move (consideration of actuality which involves adjustment). George defines adjustment as a compatible fit between the person and the environment. Successful adaptation is characterized by two conditions: the individual meets the demands of the environment and experiences a sense of general well-being in relation to the environment.  

Insights were generated on how Bible Study could serve the coping mechanisms with regard to the dislocation of the elderly. These generated insights are contributing factors with regard to pastoral care in the Institutional Geriatric Church toward the development of a model for future ministry to aging persons who are members of this church.

Succinctly, the model of pastoral care for the Institutional Geriatric Church was designed to explore the potentials of eliminating fear of movement and adaptation to the move, through the use of Bible Study, the experience of the grace of God, and a positive growth of the members of the Bible Study Group to God.

The writer discovered that it was very difficult to relate the Elderly Person in a meaningful way to the complex principles of institutionalism which often involves the

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necessity of change. One explanation for the apparent misinterpretation could be the inadequacy of the traditional one-to-one medically oriented model of pastoral care for understanding the complex forces which influence the lives of many Elderly Persons. For example, the one-to-one medically oriented model focuses upon the intrapsychic and interpersonal needs of persons and de-emphasizes the importance of the complex social, political, economic, and historical factors which influence the lives of Geriatric Persons. Therefore, it could be hypothesized that the one-to-one model does not provide the Elderly Person and the Institutional Geriatric Church with the kinds of conceptual and strategic tools that would enable the Elderly Person to develop a viable movement towards the elimination of fear, the establishment of adjustment, and a positive movement toward God.

As a result, it was deemed necessary for the writer to explore the usefulness of multifaceted behavioral science models for developing a viable model of pastoral care for the Institutional Geriatric Church.

It must be added that the examination of a multifaceted behavioral science model is not intended to prove that the one-to-one model is inadequate relative to the ministry of the Elderly Person. The task in the dissertation is exploratory in that it is intended to use multifaceted behavioral science models for the purposes of stimulating insights and developing hypotheses which would lead to further research.
C. Definitions

Terms which are central to the study are defined in this section as a means of assisting communication.

Bible study group is a group that was made up from persons who were members of the Institutional Geriatric Church. It met on a weekly basis for a twelve week period to further the purposes of Christian Education. Other learning took place as a result of group interaction and sharing experiences.

The terms elderly persons, geriatric persons or older adults refer to those institutionalized persons whose chronological age is sixty-five years or older who are retired from occupational endeavors and who suffer from mental and/or physical deficiencies such as schizophrenia, paranoia, depressive neurosis, senility, organic brain syndrome, arteriosclerosis, diabetes, heart disease, cataracts, and broken bones.

Coping with change means overcoming problems and difficulties when an impending loss, as well as the actual loss, due to change of environment occurs in the life of the elderly person.

Wimberly proposes Jernigan's view, in stating that pastoral care refers to the "total ministry of the religious

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Pastoral care then, for the purpose of this study, further means bringing to bear upon the elderly, the total caring resources of the institution emphasizing Bible Study induced by their quality of life which serves as a catalytic agent for bringing about the release from fear, the aid to adjustment, the experience of the grace of God, and a positive growth of the members of the Bible Study Group to God.

Pastoral care has its foundation in God's love manifest in His Son, Jesus Christ, and it is a part of the church's response to God's love in service to others.

The term, Institutional Geriatric Church, refers to any mental hospital accredited by the Joint Accreditation Committee on Hospitals (JACH) with a special Division of Geriatrics such as Central State Hospital in Milledgeville, Georgia. This accreditation means that the hospital's efforts to provide high quality health care have received professional and national recognition.

This type hospital will meet the standards set by JACH for accreditation which will aid in a clearer understanding of the term Quality of Life, which will be discussed on page 9 of this dissertation.

According to Grimes, all teaching occurs in a context, and Christian teaching takes place within the Christian

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community or church. "Church" must be taken to include its various manifestations: institutional church, Christian family, unconventional structures, and so on.

This dissertation is not concerned with the question that is often raised about the validity of the present institutional church as the church of Jesus Christ, nor are the many problems of the family to be considered. It is only affirmed that if the present structures of Christian community fail to be the church, or if they fail in the future, others must be found to take their place.

The institutional geriatric setting and the church are interrelated and are essentially the same, as explained here-with:

The job description of the Clinical Chaplain in the Geriatric Division of Central State Hospital states that he is responsible for ministering to and providing clinical pastoral care and services to residents, the families of residents, hospital staff, and their families. There are approximately 395 residents and 340 staff. He prepares and conducts religious services to include worship services, celebration and affirmation services such as the various sacraments, burial of the dead, etc. He leads individual and group therapy sessions and consults with other staff regarding residents' treatment/evaluation. He provides pastoral counseling to residents and staff when appropriate. There is hardly a week in the year when a resident and/or hospital staff member does not call on the pastor (the clinical chaplain) of the Institutional Geriatric Church for counseling on personal or hospital related problems.

Other duties include pastoral visitations, teaching religious education classes, seminars, coordinating the

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8 Ibid., p. 33.
efforts of individual volunteers and serving as administrative supervisor to clinical pastoral education students as they are assigned to the division for intern work. Although the writer completed four quarters (one year) of full time internship as a clinical pastoral education (CPE) student, he is not a certified supervisor of this program. Therefore, no further reference to this area will be made.

He serves as a member of the treatment team of the two admission wards and as a consultant to treatment teams of the other eight wards. He also performs pastoral caseload administrative work, such as maintaining progress notes of visits and counseling sessions. Thus the parish of this clinical chaplain, consisting of residents and staff, total a fluctuating membership of 735. Therefore, for purposes of this dissertation, the Institutional Geriatric Church is the Geriatric Division of the Central State Hospital. For additional reading, see the next section, Theological Norms.

The term model is defined in the dissertation according to its usage. In this context the term model refers to that structure which will be utilized to design a ministry to Elderly Persons coping with change. This structure will be developed to organize and analyze data from the teaching of the previously organized and established Bible class to elderly persons for the purpose of furthering Christian Education. This structure will also be developed to organize and analyze data from this Bible class for the purpose of establishing goals and suggestive ways of implementing these goals through concrete strategies.

According to Wimberly's summary of Russ-Eft and Steele's research, quality of life which is impacted by education is embodied in five major headings: (1) material and physical well-being, including financial security, physical and mental fitness, including financial security, physical and mental fitness, 

and health problems; (2) relations with older people--with spouse or other close companions as well as other relatives in the family of origin and the family of procreation, and with friends; (3) social and community and civic activities which refer to helping activities and participation in voluntary associations, and freedom of participation in, as well as having appreciation for, political, social, and religious activities; (4) personal development and fulfillment including intellectual development, a personal understanding of living, using one's abilities through engagement in interesting, challenging, rewarding and worthwhile work in a job or at home, and demonstrating creativity and personal expression--ingenuity, originality and imagination in areas such as the arts; and (5) recreation which involves socializing, passive and observational activities, and participatory recreation.

An impact of education upon the quality of life may be observed in Wimberly as she summarizes the importance of lifelong education by emphasizing that education is a fundamental source of knowledge and understanding. To this degree,  

Education has a therapeutic aspect that makes it compatible with pastoral care in the Institutional Geriatric Church. When a situation is thoroughly understood and when there is something that we can do about it, it ceases to be so fearful. Knowledge dissipates enshrouding fear which hampers happiness similarly as radar enables us to "see" through the obscurity of fog, darkness, or storm. See page three. Education serves in like manner to adjustment. See page four. At this point, Elderly Persons, in the context of this dissertation, have an opportunity to experience the saving grace of Jesus Christ and the liberation powers of God can be manifest in their lives. Moreover, this can also be a turning point in their lives manifested by their growth to God. See Theological Norm section of this chapter. The very high degree of their quality of life may serve as a common denominator in determining the outcome of the Bible Study Group as discussed in the Evaluation Chapter.
education serves as a principle modifier of attitudes, behavior and skills—a process which should be ongoing. In rejecting terminal education, she further refers to Eklund who promotes a process of "...learning, unlearning, and re-learning; as well as learning to learn and upon learning to want to learn." The involvement of older adults in this process is seen as an alternative to apathy, the consequences of which are withdrawal from life and the preclusion of possibilities for self-renewal.

Liberation is the recognition and release of potential in persons to act on life possibilities in present and future life in spite of limitations.

D. Theological Norms

In order to relate the resources of the Institutional Geriatric Church with the theories emerging from the behavioral sciences it is necessary to examine the criteria for deciding what is relevant or irrelevant from the behavioral sciences. The criteria which decide the relevance of material for the dissertation are called the norm. In pastoral care,

12 Ibid., p. 17.
the norms must be theological, and they are the result of
the interaction of a community and the revelation of God in
Jesus Christ, and they assume that the source of all Chris-
tian norm is God.

The theological norm is the hermeneutical principle
which is conclusive distinction in specifying how sources
are to be used by rating their importance and by designating
the relevant data from the irrelevant. For example, most
theologians would agree that the Bible is important in the
theological task. Recognizing the fact that there are sixty-
six books in the Bible, the question arises concerned with
how we are to decide which books are more important than
others. This question would bring answers ranging from the
fundamentalist's verbal-inspiration view to the archliberal
view that the Bible is only one of many records of man's re-
ligious experiences. In every specification, the importance
and use of the Bible are determined by the theological norm
which is brought to the Scripture. Theologies with the key-
note as a kerygma basis would like to portray that the norm
arises from Scripture itself, yet this is not always easy to
determine. What is true is that the theologian brings to
the Scripture the perspective of a community, and what is to
be hoped is that the community's concern is consistent with
the concern of the community that gave us the Scriptures.

It is the task of theology to keep these two commu-
nities (biblical and contemporary) in constant tension,
correlatively speaking, in order to speak meaningfully about God in the contemporary situation.

In the context of this dissertation, the contemporary community is the Geriatric Division of Central State Hospital. Therefore, the above-mentioned task must be carried out by a Christian Theology which is specifically concerned with the current situation of the Geriatric resident. This particular theology must, of necessity, be a geriatric theology. In this context, the theology of the Institutional Geriatric Church is the Geriatric Theology.

Geriatric Theology is a rationale primarily concerned with a study of the being of God in the above-mentioned world of these elderly persons in the light of the existential situation of an estranged community relating the forces of liberation to the prime focus of the gospel, which is Jesus Christ. Therefore, its only reason for existence is to put, in concrete and uniform order, the language of the meaning of God's activity in the Institutional Geriatric Church so that this community of the estranged will recognize and understand that their individual inner thrust for liberation is not only what the gospel is, but actually is the gospel of Jesus Christ.

A genuine norm is an expression of the nurturing environment which informs the development of the norm. Thus, the norms are shared creations which are religiously and culturally motivated and are the result of the encounter of the church with the Christian Gospel.  

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Geriatric Theology seeks to create theological norms which are in harmony with the institutional geriatric condition and the biblical revelation. The geriatric theological norms must not be private norms of a particular theologian but must arise from the geriatric community itself. This means, for the purpose of the dissertation, that there can be no norm for the Institutional Geriatric Church which does not take seriously the fact that this is an estranged community of Geriatric Persons who have left most of their worldly possessions behind; who once made their own living and managed their own money and must now depend on others for these services; who have left their familiar surroundings, family, and friends and possibly may never have the opportunity to live a "so-called" normal life again in the world of American society.

Even church members of the "so-called" normal church have looked at them with askance, and they experienced a greater degree of difficulty in finding spiritual succorence when a visit is made to the "old home church" where some are a part of the history of the individual church's maintenance and growth. Some were even listed among the founders and some were members since childhood and the only church they now have and, for many, the only church they will ever know is the Institutional Geriatric Church.

On occasion, some residents suggest that their life-long accumulations are claimed by their children (who were reared in sweat, tears, and labor--yes, and joy, too) and,
having cast them aside, claimed their accumulation of life-long labors, through legal processes, as an inheritance without previous knowledge or permission. They have a further significant existential need. This particular need is the establishment of integrity in their new situation and to know, of major importance, that God has not forsaken or deserted them in this, the last stage of their lives.

The norms of this dissertation are shared creations. They have emerged as the result of the Institutional Geriatric Church's encounter with the revelation of God in Jesus Christ. This encounter was and is with the God of history who became involved in humanity's struggle for liberation from existential estrangement. In the struggle for Geriatric Christians for liberation, the following words of the Scripture in the Gospel of Luke (as Jesus Christ preached in the synagogue) concerning liberation are of great significance:

The Spirit of the Lord is upon me, because He has anointed me to preach the good news to the poor. He has sent me to proclaim release to captives, and recovery of sight to the blind, to set at liberty those who are oppressed, to proclaim the acceptable year of the Lord.  

The Christ who brought liberation to mankind is the foundational norm of this dissertation. The liberation ministry of the Institutional Geriatric Church is built upon this norm, and the following outline represents the specific dimensions of the liberation norms as it relates to the liberation ministry of the Institutional Geriatric Church.

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1. The liberation ministry of this church involves the recognition and release of potential in persons to act on life possibilities in present and future life in spite of limitations. Such liberation means a clarified perception of the state of being of the resident; a relief or deliverance from sorrow, suffering or trouble; and a movement of the capability of the individual resident toward the development into actuality, the release from fear, the aid to adjustment, the experience of the grace of God, and a positive growth to God.

2. The goal of the liberation ministry of this church is to free persons to respond to God's love in Jesus Christ through increasing the person's ability to grow in love toward God, self, and neighbor (To better understand this goal, read further in this section, the operational theological norms).

3. In the liberation ministry of the Institutional Geriatric Church the source of all growth potential is God. It is through God's power manifest in Jesus Christ that the residents' capacity to adjust themselves to their current situation is released, and through His power that their ability to make a religious commitment is actuated. It is through the power of God to influence the growth
of the resident in a positive way. It is also through God's power that the resident gives up the obvious crippling self-image and is restored to an essential nature with God.

The goal of the Liberation Ministry in this church is the operational theological norm. The operational theological norm in this dissertation is the liberation of Elderly Persons for a positive growth toward God, the acquisition and/or strengthening of a basic integrity of the life they have lived, a religious commitment to the present and the future, and also the building and maintenance of love for self, for contemporaries, and for other members of the Institutional Geriatric Church.

In the context of this dissertation the fear of movement and adaption to the move not only represents an opportunity for the Elderly Person to experience the saving grace of Jesus Christ (which serves as a period of time when the liberation powers of God can be manifest in their lives) but, also, as an opportunity for a turning point to occur in their lives as manifested by their positive growth to God, acquisition and/or strengthening of a basic integrity of the life they have lived, a religious commitment to the present and the future, as well as the building and maintenance of love for self, for contemporaries, and for other members of the Institutional Geriatric Church.

The aforementioned norms are general in nature and are intended to serve not only as a general theological
foundation and guide for building a model of pastoral care for the Institutional Geriatric Church but also as means for establishing criteria by which the usefulness of the model of pastoral care for the Institutional Geriatric Church is evaluated. In other words, the norm will serve as guidelines for selecting what is relevant to the model from the behavioral sciences and for selecting criteria for evaluating the model.

It must be added here that the criteria for evaluating the usefulness of the model for ministry to geriatric persons in crises will be established as a result of an exploratory examination of the Institutional Geriatric Church quality of life. Therefore, the selection of criteria from this quality of life will be guided by the norm of liberation.

E. Methods of the Dissertation

There are two methodologies to be employed in the dissertation: the exploratory research method (such as the research of the literature that is available on the subject) and the theological method of correlation. The exploratory research method, which is the first method of the dissertation, will attempt to examine the usefulness of the latest prevalent theories of aging for developing a model of pastoral care by applying theoretical concepts from these latest prevalent perspectives and a theological perspective to case study data from a Bible Study Class in the Institutional Geriatric Church for the purpose of stimulating insights which would lead to further research.
While the usefulness of the exploratory method lies in the manner in which it stimulates insights for further research, it must be supplemented by another method for developing the theological nature of the study. It is this supplemental method, the theological method of correlation, which constitutes the second method of the dissertation.

Three emphases in recent theological thought appear to be especially relevant to methodology. Two serve defining purposes and the last is functional in usage. The first of these is often associated with the name of Paul Tillich, though it is not exclusively his: namely, the principle of correlation. By this it is meant the attempt of theologian and educator to find those points at which the "given" of the Christian faith intersects or correlates with the "given" of the human situation. That is, the questions of life (or persistent life needs) find their "answers" (or counterpart) in the Christian faith. As Claude Welch has put it, "The theological task and the task of interpretation involves us inescapably in both the language of the church and the language of a contemporary situation...the interpreter or educator who stands within the Christian community also stands, and must stand, in many other communities if his is to be a genuine interpretation to persons."  

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Edward Wimberly's emphasis in theological thought is more specific in the context of this dissertation for the understanding of correlation in that it will be employed in the architectonic structural development of the model. He states, "Through the use of the correlational method, data is analyzed by way of application of a theological perspective and several behavioral science perspectives; more specifically, the model of pastoral care will be developed by examining what the differing frames of reference have to say to each other analogously as a result of their analysis of common data." The two models employed differ from each other in that the overall purpose of the dissertation is an exploratory search for a model which would serve as a theoretical framework for further research, whereas, the correlation method will serve the purpose of constructing the actual model.

To be more specific about the detailed use of the two methodologies in the dissertation the organizational structure will be outlined.

1. In the second chapter of the dissertation an examination of the literature concerning six of the latest theories of aging will be undertaken with the precise purpose of discovering the questions and implications to which a model of pastoral care for the Institutional Geriatric Church must respond.

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2. In the third chapter, the setting in which the project was carried out will be examined for a better understanding of the community from which the norms of the dissertation must arise and the data (case studies and a systematic report of each session of the Bible Study Group) will be presented.

3. In the fourth chapter, the data obtained from the Bible Study Group will be evaluated from the writer's theoretical perspective from which will be drawn implications for a model of pastoral care for the Institutional Geriatric Church.

4. In the fifth chapter, the data obtained from the Bible Study Group will be evaluated from the writer's theological normative perspective from which will be drawn implications for a model of pastoral care for the Institutional Geriatric Church.

5. In the sixth chapter, a model of pastoral care for the Institutional Geriatric Church will be developed based upon a correlation of theories of aging with a system of theological concepts reflecting the nature, purpose, and meaning of the church's ministry. This model is only a design, however, which will serve as a basis for organizing material when implications are drawn from the analysis of the data.

6. The final chapter will report on the conclusions of the study, the limitations of the study, and the hypothesis generated by the study.
F. Review of the Literature

As stated earlier, very little has been published which focuses upon pastoral care in the Institutional Geriatric Church; however, a few selected published works helped to shape the writer's conceptualization of the problem.

In terms of pastoral care, a growing emphasis has emerged in recent years upon the role of social structures and social forces in helping to shape the human personality and their contribution to the continuity of the human personality throughout life. This is reflected in Anne E. S. Wimberly's publication, *A Conceptual Model for Older Adult Curriculum Planning Processes Based on Normalization and Liberation*, which is a demonstration in the relationships of normalization and liberation and their use in her model to the life quality of older adults. Her concept of the quality of life and the value of lifelong education for older adults is of prolific importance to this dissertation. Moreover, the Church's concern in this area may be observed in Marvin J. Taylor's editorship of the work, *An Introduction to Christian Education*, which focuses upon curriculum theory and materials, age group ministries, religion, the institutional church and other institutions such as public

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schools, the Christian family, unconventional structures, etc. As well, it presents an opportunity to examine the whole matter of recent Protestant strategies for Christian Education in its undergoing searching analysis and evaluation. Catholic and Jewish chapters further concern a minority of the members of the Institutional Geriatric Church, which contributes to the curriculum planning of future educational processes. More than this, there has been a growing concern for cultural influences which help to shape pastoral and Christian theologic concerns in ethnic, racial, and special society communities. This is made apparent in Edward P. Wimberly's textbook, Pastoral Care in the Black Church,22 which utilizes Systems and Crisis Theories to construct a model of pastoral care in the liberating ministry of the Black Church, and in James H. Cone's publication A Black Theology of Liberation,23 which offers a Christian theological base of planning and operation in the liberating ministry of an estranged community. A further reference to the process of theological understanding is found in the work of L. Harold DeWolf, A Theology of the Living Church,24 which is a presentation that brings theology into relation with other intellectual and practical interests. He assumes that theology must not only be communicated in language and modes of thought


universally recognized and understood, but that it remain flexible enough to interpret day-to-day reality. He further suggests, in relation to the existing Church, a bridging gap between the formal theology of the seminaries and the needs of the people of the churches to which the pastor must minister.

In addition to increased interest in the role of socio-cultural factors in pastoral care there is a growing interest among Gerontologists upon fashioning a model of change and adaptation in the day-to-day business of ordinary living. A firm effort in this direction is seen in Linda K. George's publication, Role Transitions in Later Life, which suggests that the majority of older adults construct quite successful adaptations to transitional stress. She further notes that they adequately negotiate environmental demands, report relatively high levels of life satisfaction, and maintain a meaningful sense of personal identity. She also is concerned with the role of history and culture in the analysis of behavioral aging. And then, she relates the interplay between continuity and change as human aging is examined. She suggests, in her model of transitional stress, that how we negotiate the changes of tomorrow is in part forecast by what we are today.

Finally, two works explicate an overview of the psychological and social significance in the development of

\[25\] Linda K. George, Role Transitions in Later Life.
recent theories of aging: James E. Birren and K. Warner Schaie, eds., *Handbook of the Psychology of Aging*, 26 and Robert H. Binstock and Ethel Shanas, eds., *Handbook of Aging and the Social Sciences*. 27 The latter publication, Binstock and Shanas in particular, places an emphasis upon the continuity of life theory which is a major concern of this dissertation. Bernice L. Neugarten is cited for her contribution to this handbook concerning age and social interaction. Because of the increase in literature about the many facets of aging, this work is published to meet, to collate and interpret existing information and to make it readily available in systematic form, providing groundwork for the more efficient pursuit of exploration and research. Here it is recognized that the phenomena and issues of aging cut across many scientific disciplines and professions, and a review of research necessarily involves many experts. This book was written in a symposium form to develop a multidisciplinary project, the purpose of which was to organize, evaluate, and interpret research data, concepts, theories, and issues on the biological, psychological, and social aspects of aging.

In the next chapter a more detailed account of literature relevant to the problem will be examined for the purpose


of deriving questions to which a model of pastoral care for the Institutional Geriatric Church must respond.

G. Limitations of the Study

In this section consideration will be given to what will be included and excluded from the study.

As a first consideration of limitations it is here-with stated that the legal aspects of confidentiality will be observed in any discussions of Central State Hospital in Milledgeville, Georgia, the residents residing therein, and the four case studies to be analyzed.

In terms of the development of the model for the Institutional Geriatric Church, only theories of aging will be examined for their relevance to developing a model of pastoral care for the Institutional Geriatric Church.

In terms of theories of aging the study will be limited to explicating the development, nature, philosophical assumptions, conceptual framework, and strategic tools of theories of aging for the purposes of outlining background material for the development of a model of pastoral care for the Institutional Geriatric Church. In terms of analyzing case study data from a continuity of life theory perspective the study will be limited to the definition of quality of life by Anne E. S. Wimberly.

The proposed model of pastoral care will exclude any primary emphasis upon the behavioral science models and strategies which are known under the rubric of one-to-one
model. More specifically, the long-term intrapsychic, insight orientations will be excluded from the model, while the more short-term, task-oriented models will be emphasized in this model.

The development of the proposed model of pastoral care for the Institutional Geriatric Church also has limitations in terms of how it will be used within local Institutional Geriatric churches. Since the research in this dissertation is primarily exploratory and not experimental, the model is limited to the four case studies and cannot be generalized to other Institutional Geriatric Churches. Therefore, the model is intended only as an example or illustration of what is possible, and each Institutional Geriatric Church must design its own model of pastoral care based upon its own peculiar needs. The proposed model in the dissertation is intended to stimulate experimentation by local Institutional Geriatric churches. Therefore, the model to be developed in this dissertation is not the model of pastoral care for the Institutional Geriatric Church; rather it is only one model that may be employed in Institutional Geriatric local churches.

This study also has limitations on the rapidly increasing literature on theories of aging. The literature is vast in this area and the writer's intent is the selection of representative samples of the literature for the dissertation. However, the exploration of the literature will be limited to discovering the questions to which a model of pastoral care for the Institutional Geriatric Church must respond.
This study also has limitations relative to the small amount of available literature on the Institutional Church. The review of the literature on the Institutional Church will be confined to publications relating to what church historians, theologians, anthropologists and sociologists have to say concerning the therapeutic role of the Institutional Church and the significance of this role in relationship to the socio-economic situation of Elderly Persons in America. The literature is minute in this area and the writer's intent is the selection of representative samples of literature for the dissertation. However, the exploration of the literature will be limited to discovering the questions to which a model of pastoral care for the Institutional Geriatric Church must respond.
CHAPTER II

THEORIES ON AGING: QUESTIONS AND IMPLICATIONS

A. Introduction

The purpose of this chapter is to examine selected studies of theories of aging in order to identify some of the salient psycho-social needs to which a model of pastoral care for the Institutional Geriatric Church must respond. The exploration of theories of aging is also intended to raise questions and implications which can give guidance to the task of developing a model of pastoral care for the Institutional Geriatric Church.

To the ends of discovering salient questions and implications as well as discovering psychological needs, this selected examination of the relevant literature on the theories of aging will cover significant subject areas of psycho-social concerns of the Geriatric Person, such as: (a) stress and coping in late life, (b) psychodynamic aspects of coping in late life, (c) social aspects of aging and coping, (d) physical aspects and coping, etc. This examination is intended to identify important consistent trends within Geriatric concerns which relate to the Institutional Geriatric Church and which have influenced the development of the Geriatric personality in a positive way. The questions
and implications for pastoral care in the Institutional Geriatric Church will be drawn from these emergent trends identified in the examination of selected relevant literature on the Theories of Aging.

1. Theories of Aging

The function of theory in social science is to integrate current knowledge, to explain empirically based findings, and to predict new relationships. Theory is used for both the scientist and the practitioner in a field like gerontology, for it both organizes observation and suggests policy implementation.¹ A social theory of aging, if it is to meet the demands of the scientific community at least, should first of all integrate such findings as reported; second, it should offer a cogent system of explanation for the various phenomena that have been reviewed; third, it should predict the future: "If this, and this, and this occurs, then that will surely follow."

Is there theory in social gerontology that fits these criteria? Not at the present time.² It is further unlikely that we will have in the foreseeable future such theory that ties together the complex phenomena in the social and personal systems as they change through time. There are several

²Ibid., p. 41.
difficulties which have hindered progress in this area:

1. There is the lack of an adequately large and scientifically sound body of facts concerning social and psychological processes in aging.

2. Social research is extremely expensive and time consuming. A generation of humans age and change more slowly than a cohort of rats. In terms of personality changes we must wait a long time to see the manifestation of continuity or change over time.

3. The field of aging is a relatively young scientific area. The first book that may possibly be termed a social-psychological investigation of aging appeared in 1953; the first collection of comprehensive research review papers regarding sociological aspects of aging appeared in 1960.

There have been attempts, however, and a great deal of research in the field has been stimulated by attempts to tie together the multifaceted phenomena of aging under the rubric of "disengagement" or "activity" theories of aging. Though these are hardly theories in the strict sense of the word they perform much of the function of theory by systematizing some of the information about aging and making certain predictions about behavior in old age. A brief summary of these and other theories will follow.

B. Activity Theory of Aging

Activity theory suggests that the relationship between the social system and the personal system remains

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3 R. J. Havighurst and R. Albrecht, Older People (New York: Longmans-Green, 1953).


fairly stable as an individual passes from the status of middle age into the status of old age. The norms impinging upon him do not markedly change; he is still expected to do much the same as he did in the middle years, with the exception that he is allowed not to work (whether he wants to or not) and is expected to "slow down a little". When roles are taken from him, as occurs with retirement, or the loss of friends or spouse, he is expected to compensate by increasing activity in other spheres or with other people. The sources of satisfaction, his self-concept, and life styles, are not expected to change much from what they were in his middle years. In America it appears there is an expectation for general society to meet these continuing needs by structuring certain aspects of the environment (such as Golden Age centers and nursing homes) to encourage interaction more than privacy. Despite some changes in the social system, the activity theory of aging emphasizes the stability of personal system orientations as individuals grow older, and de-emphasizes the need for structural alterations of any significant magnitude.

C. Disengagement Theory of Aging

Here the aging process is seen as a mutual, and inevitable, "disengaging" of the individual and society. The individual gradually withdraws socially as well as psychologically from his environment as he moves into old age. Most

6 Ibid., p. 42.
7 R. J. Havighurst and R. Albrecht, Older People, p. 37.
importantly, the process of withdrawal is suggested to be mutually satisfying. For the individual, this withdrawal brings a release from the societal pressures for instrumental performance that tax a weakening body. For the society, this withdrawal allows younger (and, presumably, more energetic and competent) individuals to assume the functional roles which must be fulfilled for the survival of the social system. This is, of course, an example of "sociological functionalism".  

Cumming and Henry presented data to indicate that there is a measurable decrease in the individual's psychological engagement, or ego involvement, in the external environment. They interpreted their data to mean that associated with this generally lower level of social engagement and ego involvement in the external world, there is a high level of psychological well-being or, as they defined it, "morale".  

The central contribution of disengagement theory is its attempt to interrelate physiological, psychological, and social changes in old age. This theory further emphasizes the disjunctive, developmental quality of passage into old age. It suggests that old age is definitely different from middle age, marked by substantial shifts--and eventually a new equilibrium of forces--in the social and personal systems. The sources of psychological well-being in old age,  

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8 Vern L. Bengtson, The Social Psychology of Aging, p. 44.

9 Ibid., p. 44.
for example, are much different than those in middle age, when they were much more dependent on continued and face-to-face interaction with others in the social environment. Similarly, there is a difference in the extent to which the social norms impinge on the individual and are the immediate causes of his behavior: expectations are much less salient. In short, the theory points to a definite change in balance between the social and personal systems.

Disengagement theory, in contrast to activity theory, is a specific attempt to integrate findings concerning social-psychological phenomena in old age, to explain successful aging, and to state some of the conditions associated with happiness in old age.\textsuperscript{10}

Perhaps the most clear indication to the limitations of both activity and disengagement theories of aging comes from the work of Havighurst, Neugarten, and Tobin on patterns of aging.\textsuperscript{11} Here it is clear that neither model accounts for the empirical relationship of social activity, personality types, and psychological well-being. As summarized by Neugarten:

People, as they grow old, seem to be neither at the mercy of the social environment nor at the mercy of some set intrinsic processes that they cannot influence. On the contrary, the individual seems to continue to make his own "impress"

\textsuperscript{10} Ibid., p. 44.

\textsuperscript{11} R. J. Havighurst, B. L. Neugarten, and S. S. Tobin, "Disengagement and Patterns of Aging", In Middle Age and Aging, ed. B. L. Neugarten (Chicago: University of Chicago Press, 1968), Table 2.
upon the wide range of social and biological changes. He continues to exercise choice and to select from the environment in accordance with his own long-established needs. He ages according to a pattern that has a long history, and that maintains itself with adaptation, to the end of life.\footnote{12}

D. Biological Theories of Aging

There are several biological theories of aging which represent attempts to understand and explain the manner, method, or mechanism by which aging comes about. A few of these theories will be mentioned briefly.

(a). Progressive loss of reserve capacities may be attributable to cell death and depletion of functioning units, caused by increasing impairment of processes of energy use, tissue repair, and elimination. Since no physiological process functions with 100 percent efficiency, there would be a progressive accumulation of failure in the course of time. This view is related to the concept of "mean time to failure,"\footnote{13} which would view living systems as a sort of biological machine with built-in obsolescence.

(b). Age-related cell death has been ascribed to random hits by environmental factors (e.g., cosmic radiation); to depletion of vital substances with an accumulation of insoluble substances (e.g., lipofuscin); to changes in molecules, especially those involved in energy transfer (e.g., cross-linkages between molecules); and to mutations. Somatic cell mutation produces DNA changes which in turn results in changed RNA and altered protein transcription (nonsense protein).\footnote{14}


Stochastic theories focus on cell depletion through cell death or somatic mutations caused by radiation or other "hits". In time defects develop in all cells, but in organs that can replace cells, the process of mitosis can eliminate aberrant cells. However, organs consisting of postmitotic cells (e.g., neurons) cannot rejuvenate, and hence would seem to have major responsibility for the aging process. From this point of view, aging is fundamentally the progressive increase of nonfunctional cells in organs whose cells are postmitotic.

The error theory is linked to the mutation theory. The development of chromosomal abnormalities apparently is an intrinsic aspect of cellular aging and suggest the occurrence of mutation. Chromosomal abnormalities occur progressively with increasing age. Radiation further facilitates this phenomenon.

The cross-linkage (eversion) theory applies mostly to noncellular material, especially collagen. A cross-linkage between polypeptide strands changes the structure of the collagen molecule and results in functional deterioration.

Immunological factors play a role in the autoimmune theory. With time the individual develops mutant (nonsense) protein caused by transcription errors. The development of immune reactions to this "not self" protein may play a role both in the aging process per se, and in the causation of certain age-related diseases (e.g., arteriosclerosis, cancer, maturity-onset diabetes).

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17 Adrian Verwoerdt, Clinical Geropsychiatry (Baltimore: The Williams and Wilkins Company, 1976), p. 3.

The literature concerning the other selected theories of aging is extremely vast; therefore, the writer deems it expedient for purposes of this dissertation to review them in terms of an overview. Thus, the following studies of theories of environment, development, and continuity of life will be offered utilizing the general procedures of an overview presentation.

E. Environmental Theories on Aging

Conceptual models which summarize research on person-environment interaction suggest that older persons are more critically affected than younger persons by their living environment and that, with increasing age, living environments should be increasingly supportive.\(^19\)

The "loss continuum"\(^20\) indicates that with aging a person's world shrinks and his/her ability or willingness to deal with many people and with complex environments decreases. The "environmental docility hypothesis"\(^21\) proposes that the more competent the organism (in terms of health, intelligence, ego strength, social role performance or cultural evolution),

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the less will be the proportion of variance in behavior attributable to physical conditions around him/her. Proponents of this hypothesis accept a generally negative relationship between competence and aging, and perceive the solution to lie in tailoring living situations to the current competency level of their occupants.22

A general problem for the designer on environments for the elderly is how much support and how much challenge should be built into such environments. The issue of how to build in support or challenge is a closely related but, in some sense, subordinate one. An overly supportive environment robs the individual of initiative and the opportunity to exercise his/her adaptive ability, thereby maintaining it and enjoying the consequent sense of mastery and its favorable effect on self-esteem. An overly demanding environment frustrates, discourages, and further lowers competence and self-esteem. The problem of how much support and how much demand to build into living environments so that they will be optimal for older people is greatly complicated by the diversity of that group at present and the likelihood that it will become even more heterogeneous with time. At present, the elderly are the most heterogeneous age group; in the future they will be even less homogeneous. "The younger aged, the older aged, and conceivably a middle group of aged, each will be confronted with a

set of problems unique to that age level, but overlapping and impinging one on the other." This complicates environmental design for the future because the life space must be made flexible and sensitive to the changing needs of its participants. An example of the changing needs of the elderly may be observed in the fact that the person is far different during the final year of life than in the first after reaching the chronological age, retirement, or other status which defines him as old.

Even when the stages or phases of later adult life are numbered and known, individual differences among people in any one of them will be great. As Pastalan pointed out in reference to the "loss continuum", it is unquestionably true that the average 80 year old is not able to do some of the things easily done by the average 20 year old. However, it is equally true that 20 year olds are not identical and 80 year olds are even less so. Therefore, it is fruitless to contemplate design of "the" housing for the elderly or even for those in "one stage of aging". The primary orientation of innovation should be creation of a rich variety of milieus which express the aspirations and meet the characteristics of a rich variety of people.24


F. Developmental Theories of Aging

The importance of early childhood experiences is undoubted and, correspondingly, a psychodynamic investigation made into the present condition of a person will show that many personality traits are quite stable. However, it has been recognized even by many scientists working within the psychoanalytic tradition that adult development can be important and that it leads to definite personality changes. To put it another way, it has been recognized that people face new problems after adolescence which they have to solve in their own way. Thus, several varieties of neo-Freudians have extended development into later paths and periods of life and, in this way, discovered personality traits which are more appropriate to adult and elderly ages. Probably the most complete attempt of this kind was made by Eric Erikson who began as a child psychoanalyst and later extended his work to cover the whole life span. He discovered a major problem during the post-adolescent years—the search for an identity, or the identity crisis, which is different from the Freudian sexual developmental stages. Starting with this crisis, he isolated a series of problems which must be

26 Ibid., p. 411.
solved at the appropriate age. Eventually he described a sequence of eight stages, each characterized by a certain kind of problem which must be solved so that the individual can pass easily into the next stage. Personality traits will develop at each stage depending on the resolution of each previous conflict. In fact, however, in the description of his theory, even Erikson devotes much more space to the earlier stages which take an individual through adolescence than to the later stage which describes the rest of the individual's life cycle.

The great importance of early childhood and the attention given to it by psychologists are not confined to those who work within the psychoanalytic framework. The same imbalance is found in cognitive and structural theories. In establishing a theory related primarily to intellectual and cognitive development, Piaget defines a development of steps toward a logical understanding of the world but, once this is achieved, he seems to assume a future leveling out of development. The achievement of cognitive maturity is cumulative and is not unlearned in the later stages of life. Thus, the achievement of logical understanding, accomplished by the end of adolescence, is considered the main developmental task.

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One might go to the opposite extreme from the Freudian theorists and state that the personality asserts itself gradually over the life span. Although few would claim that the aged exhibit the basic personality in its purest form, the emphasis on self-realization and similar terms by some personality theorists points in this direction. They see human development as a struggle to realize one's essence, to reach the possibilities of one's being in the purest form; one could say that they see a continuous progression of a chreod to a pure form.30

G. Continuity Theories of Aging

Taking an extremely long range view with genetic and evolutionary emphasis, one looks only at slow and gradual adaptations. Each person is simply a step in a long sequence of generations. Socially we find the analogue of this approach in family histories where each character is taken as a whole representing his own generation.31 Sociological family studies show a prevailing influence over the whole life span, leading to extreme creative or pathological results.32 Not much attention is given to change. For the

new generation, the aged person represents only the memories of his own youth.

More central to questions of individual development are the physiologically oriented theories which derive human behavior from some constitutional pattern that persists throughout life. 33 This approach has a long tradition, from the "humors" of the ancients to phrenology. Recent theories have taken a variety of physiological conditions into account. Among the more popular ones, Sheldon's 34 typology uses a number of measurements to determine the somato-types which are related to corresponding character types. Other theories do not try to explain the whole personality constellation, but only specific tendencies or traits. In addition, research on particular physiological effects, such as glandular deficiencies and nervous development, has been used to explain some constitutional patterns. To a smaller degree the same sources may explain long lasting personality differences. These theories take the biological developmental work as a model and are, therefore, led to the same question: What is it which controls the consistent creation of particular forms over the life span?

Some theories try to ascribe single causes for human behavior; they are usually designed to treat extreme or pathological cases. Conditions such as body build, glandular secretions, and development of nerve nets\(^{35}\) can determine behavior if they are beyond the normal range. However, small variations within this range are not sufficient to guide the whole life course.

A modern variant of these somatic theories puts the predetermining causes into early experiences of the individual. These theories propose that some event or constellation in early childhood will determine the course of life. Orthodox psychoanalysis can be taken as the model for this perspective. The work of the psychoanalysts and psychodynamically oriented theorists has established clearly the importance of early childhood experiences, especially of unusual or painful ones. Again, we must stress the point that this work was principally designed to expose sources of pathological behavior, not to deal with variations in the normal range.

The strict psychoanalytical theories look for lifelong determination of character during the pregenital stages, that is, before adolescence. The way in which a person reaches genital maturity and the completeness of maturation will determine character, personality tendencies, and behavior in future years. One implication of this view is that basic tendencies of the personality do not change appreciably

after this time. Thus we have here an equation, setting equal on the one side the deep-seated, interacting tendencies of the personality and on the other, earlier events in the lifetime. Biographies of two of Freud's classical cases have shown how circumstances in the later parts of life can modify the personality of individuals who seemed to be caught in a neurotic pattern established in childhood.

Although this classical, Freudian approach is not generally applied in its pure form today, its general ideas have great influence in theoretical consideration of adult behavior. In general, most textbooks or theoretical discussion will devote more time to childhood or adolescent development than to changes during the adult and later years. The middle years are considered to be the standard from which all other ages are to be explained as either leading to this period or leading away from it; thus most discussion is devoted to the stages which build up the personality patterns which are then supposedly stable during the middle years.

1. Continuities of Personality in Relation to Continuities of Coping Stances into Old Age

Personality theories have been chiefly concerned with extending continuities through time. The very concept of


38 Kurt W. Back, "Personal Characteristics", p. 11

personality assumes a continuity in time over the course of life. For practical purposes, any personality theory assumes that one can learn more about the actions of a person by knowing something of his past and previous adaptions rather than by knowing about his immediate situation. In general, therefore, personality theories are better able to explain continuity than to explain change. In the same way, they concentrate on the individual and not on the situation in which he moves. Therefore, the changes are conditioned through events within the individual and not through events that might impinge on him. This is, of course, not entirely true. To be handled effectively, individual problems and changes must be worked out within the environmental effect, personality theories discuss intrinsic change—a change which would occur within the individual, based on previous experience or because of inevitable workings within him/her.

a. Stress and Coping in Late Life

Individuals differ in the ways in which they react to stressful or potential stressful situations. Some people "fall apart" and are unable to cope with the slightest difficulty, whereas others appear to handle even the most difficult situations with grace and competence. In spite of the obvious significance of the personal styles individuals use to confront stressful situations, behavioral scientists have only begun to

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41 Ibid., p. 412.
describe and understand coping, and they are still largely unable to assess the effectiveness of specific coping strategies.  

Coping may be defined as the covert and overt behaviors individuals use to prevent, alleviate, or respond to stressful situations. This definition encompasses behaviors directed toward altering the perception of stress and the emotional distress associated with life problems as well as efforts to alleviate stressful situations. Since coping skills are used to respond to stress, they can be viewed as valuable personal resources.

Assuming that the concepts of stress and crisis are highly related, the author of this paper suggests a theoretical observation: Persons in crisis can be distinguished from persons who are not in crisis situations. Wimberly suggests a significant commonality in the behavior of individuals in a wide variety of situations which are called crisis; and commonalities are consistent irrespective of differences in the level of psychopathology or type of crisis situation. Therefore, if there is a "togetherness" in the basic understanding of these two concepts, it stands to reason that persons in stress may be identified from persons who are not in stress and that there is a similar consistency of symptoms regardless of the intensity of the stressful situation.

43 Ibid., p. 30.
A further observation may be suggested at this point. There is a difference in the psychiatric elderly patient and the "so called" normal aging population. For an example, we may consider the fact that for any loss (a crisis) or stress to become meaningful, it has to be perceived, registered in the mind, and evaluated through the process of apperception. Apperception refers to a mental scanning process of comparing incoming stimuli and images with those already stored in memory.

The fact of a loss cannot be undone by the ego, but it is possible for the ego, through its defensive mechanisms, to try to prevent the loss from reaching conscious awareness.\(^45\) The situation may become rather complex when the ego itself is changing as well, e.g., in organic brain syndrome. In these instances, the ego's ability to perceive reality is impaired and the impact of losses may be blunted. Reality perception may also be diminished through a process of withdrawal which prevents the individual from feeling the pain that would have come with clear awareness of having suffered a loss, a factor that may play a role in the development of senile regression.\(^46\)

When certain events have precipitated a crisis, persons usually go through a series of phases which run their course

\(^{45}\) Adrian Verwoerdt, Clinical Geropsychiatry (Baltimore: The Williams and Wilkins Company, 1976), p. 16.

\(^{46}\) Ibid., p. 16.
between four and six weeks providing there are no other difficulties involved. 47 These phases of crisis include the following: (1) a threat to one's basic needs; (2) a rise in tension; (3) calling forth habitual problem solving mechanisms; (4) failure of habitual problem solving mechanisms; (5) calling forth emergency problem solving mechanisms; and (6) the resolution or non-resolution of the problem. During these six phases, the person in crisis feels helpless, his thoughts are confused, and behavior changes occur which are accompanied, at times, by perceptual confusion. 48

Many factors influence the successful outcome of a crisis. Among these factors are the person's choice of coping mechanisms, the success or failure in meeting earlier crises, the availability of external resources, communications in the cultural milieu, the personality of the individual, and the bodily state of the person. 49

Here, we find that George emphasizes personality. Coping includes personality, or attitudinal, components as well as specific strategies. 50 In contrast to behavioral alternatives and strategies which probably differ according to the nature of the stress and the area of life experience involved, the personality or attitudinal consists of more

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47 Edward P. Wimberly, "A Conceptual Model for Pastoral Care", p. 73.
48 Ibid., p. 74.
49 Ibid., p. 75.
50 Linda K. George, Role Transitions, p. 32.
general and stable personal predispositions, which may be identified as personality traits, attitudes, and beliefs.

Coping can occur before, during, or after a stressful situation. Preventive coping is used to deter a potentially stressful situation. When a stressful situation can't be prevented, anticipatory coping can sometimes alleviate some impact. Anticipatory coping refers to efforts directed toward "easing the blow," or preparing in advance. Finally, coping responses can (and usually do) occur following a stressful situation.

Coping itself is a process. First, during the "search and organize" stage an individual seeks out and evaluates behavior alternatives. Then during the "implementation" stage, he or she puts new behavior into operation. Finally, during the "culminate, conclude, and redefine stage," the individual performs affective and cognitive tasks in order to accept the stressful situation and the way in which it has been handled. This final stage permits individuals to incorporate experiences into their identities.

Behavioral coping strategies include a wide variety of actions directed toward either changing stressful situations


52 Linda K. George, Role Transitions, p. 30.

53 Ibid., p. 30.
or alleviating distress. Cognitive emotional strategies refer to the ways in which individuals alter their subjective perceptions of stressful situations. Defense and denial are used to refer to these cognitive/emotional reappraisals. \(^{54}\)

Four coping strategies individuals use when their views are contradicted by valued peers are suggested. \(^{55}\) In such cases, individuals can (1) change their views to conform to those of their peers, (2) reject their peers, viewing them as less competent than expected, (3) devalue the issue in question, or (4) deny the amount or extent of disagreement.

Coping includes personality, or attitudinal, components as well as the use of specific strategies. In contrast to behavioral alternatives and strategies which probably differ according to the nature of the stress and the area of life experience involved, the personality or attitudinal component consists of more general and stable personal predispositions. George has identified three general classes of predispositions: personality traits, attitudes, and beliefs. \(^{56}\)

**Personality Traits.** Four personality traits are suggested as important elements of coping styles: chronic anxiety, openness to new experience, impulse control, and a tendency to deny the experience of threat. High levels of chronic anxiety are detrimental to effective coping for a number of reasons. Anxiety is likely to sensitize an individual

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\(^{54}\) Ibid., p. 31.

\(^{55}\) Ibid., p. 31.

\(^{56}\) Ibid., p. 32.
to the perception of stress, interfere with the appraisal of relevant behavioral alternatives, and hinder an individual's ability to implement behavioral goals. Openness to experience, which reflects an underlying acceptance of change and a flexible stance toward the environment, facilitates coping. Poor impulse control is viewed as detrimental to effective coping, because it usually precludes well-planned action that is based on adequate information about the range of behavioral alternatives. Similarly, denial is not viewed as an effective long-term coping response. The prevailing view suggests that the realities of the stressful situation will eventually resurface and that denial will have prohibited the gathering of adequate information on which to base a constructive behavioral plan.

**Attitudes.** Several attitudes are relevant to coping. The most important of these is a sense of self-efficacy—a basic belief in one's ability to initiate and control personal experiences. A perception of oneself as an active agent, in control of one's life course, is another component of effective coping.

**Beliefs.** Beliefs regarding the nature of the world (the external environment) are relevant to effective coping. A sense of basic trust in the world—a perception of the world as an orderly, predictable, and responsive environment—is conducive to effective coping. Conversely, feelings of anomie or distrust hinder an active, organized coping stance.

In general, then, personality and attitudinal factors appear to operate as predispositions to the likelihood of an
active, masterful coping style. Consequently, we would expect these factors to correlate highly with the behavioral coping strategies individuals choose when confronting a stressful situation.

Very little is known about coping skills in later life; however, there are no compelling reasons to believe that coping styles are strongly related to age. \(^{57}\) Throughout adulthood, individuals probably develop and refine a repertoire of workable coping strategies that are compatible with their personal dispositions and lifestyles. This viewpoint is suggested in two classic studies of later life. In a study of adjustment to retirement, Reichard, Livson, and Peterson \(^{58}\) described five basic types of personalities. The mature, rocking chair, and armored men exhibited adaptive personality styles: mature men were characterized by healthy realism, rocking chair personalities were passive-dependent individuals who quietly accepted life, and armored men who had highly integrated defense mechanisms that shielded them from the perception of stress. The two less healthy personality styles were the angry men, who were typically bitter, rigid, and aggressive, and the self-haters, who were also angry, but who channeled their anger against themselves.

\(^{57}\) Ibid., p. 34.

In another study, Neugarten and her associates developed a four-category typology of personality structure: integrated, passive dependent, armored defended, and unintegrated. As these labels suggest, Neugarten's categories were very similar to those of Reichard and her associates. The studies mentioned here suggest that the personality structures displayed reflect long-term, stable, coping styles.

A substantial amount of research has focused on specific attitudes or personality traits that may be relevant to coping. For example, studies have examined levels of internal versus external locus of control. The findings consistently indicate that older persons exhibit high levels of perceived internal control—higher levels than those of younger persons. Since a sense of self-efficacy is associated with effective coping, this pattern bodes well for the coping stance of most older people. However, a variety of laboratory studies suggest that older persons' coping styles are hindered by a tendency to be cautious in the face of risk and to become highly anxious when confronting performance situations.


The aged person's environment is characterized by changes which are stressful in varying degrees. Stresses in the external environment include loss of occupation, income, and prestige. In the internal milieu, decline in all biological systems is obvious.

In living organisms, the response to a stressful event is a reaction aimed at removing or neutralizing the stress and repairing the damage. On the cellular level, for example, there is the formation of antibodies and other immune mechanisms. Specific cells or organs play a major role in physiological defenses: white blood cells, spleen, adrenal glands, etc. The same principles apply to phenomena on the psychological level. A mental stress or psychotrauma leads to a psychological defense or a behavioral coping pattern.

In dynamic psychopathology, we need to differentiate between the following: the stress itself and the immediate emotional distress caused by it (e.g., loss of a spouse resulting in immediate distress of grief); the defense mechanisms employed to deal with the stress and its associated distress (e.g., denial); and the psychological and behavioral phenomena associated with or resulting from the defense mechanisms (e.g., denial leading to neurotic depression or patterns of hyperactivity). These processes tend to unfold in temporal sequence, but in such a way that each phase is superimposed on the preceding one. There is, of course, some overlap throughout.62

62Adrian Verwoerdt, Clinical Geropsychiatry, p. 22.
Emotional distress includes various negative feelings such as fear and anxiety, grief and depression, shame and guilt, anger and hostility, and so forth. It is important to keep in mind that there is no such thing as an abnormal feeling per se. What makes feelings abnormal is not so much their quality, but the extent of their duration, their intensity, and the appropriateness in the context. Thus, sadness and grief are an essential aspect of the experience of living; it would be abnormal to never feel sadness and grief. These same feelings, however, if more prolonged and severe become pathological, i.e., a depression.

Fear is the normal emotional reaction to impending injury or loss. Primary anxiety (or traumatic anxiety) concerns the response of the organism to maximal internal and external stimulation. Signal anxiety is the warning signal in response to impulses and fantasies that might result in disaster. This type of anxiety is the signal of an internal danger situation relevant to ego-alien impulses. In old age, signal anxiety becomes less important. Also, traumatic anxiety as a response to overwhelming stress is relatively unusual, although it does occur. Thus, the nature of anxiety in the aged does not correspond to primary (traumatic) anxiety, nor to signal anxiety. According to Zetzel, anxiety in the aged resembles the type of anxiety stimulated by fear of loss and separation.\[63\]

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A danger anticipated may be actual (real) or imagined (existing in fantasy only). The more a person reacts to imagined dangers and losses, the more the psychological capacity of reality evaluation is impaired. In a neurosis there is only a mild to moderate impairment of reality testing, whereas in a psychosis the impairment of contact with reality is severe or total. Thus, a psychotic patient may live entirely in a fantasy world. Some aged individuals, for example, withdraw from reality and retreat into their inner self in order to live off their memories.\(^64\)

The normal emotional response to a loss which actually took place is a grief reaction.\(^65\) This should be distinguished from depression which, although difficult to define in exact terms, is generally considered as a pathological emotional reaction. A grief reaction involves a clear and conscious recognition, on the individual's part, of an actual loss. After the initial emotional shock on the part of the bereaved person, there is an increasing realization of the significance of the loss and all its ramifications in everyday life. During this period there are recurring episodes of specific physiologic distress, such as waves of sadness. The feelings of bereavement and sadness are expressed verbally and nonverbally, e.g., crying. Toward the end of the grief reaction, which may last

\(^64\) Adrian Verwoerdt, Clinical Geropsychiatry, p. 23.

for several months, there is a resolution which involves a re-directing of energies and interests toward new people, goals, or activities.  

When a close person is lost, the psychic energy invested in that person first has no place to go, but eventually the resolution of the grief reaction results in a reinvestment of this psychic energy in new objects, in the direction of other people. However, when part of the self is lost (e.g., amputation), resolution of the grief reaction is more complex and involves a form of inner realignment and reappraisal of the self and one's relations with others. Adjustment of the latter type is characterized by continuation of self-esteem, rooted in a religious or philosophical framework that views personal worth on the basis of one's intrinsic value as a unique person; by accepting and integrating the limitation into a new self concept; and by finding new ways of maintaining closeness to others and realizing remaining potentials.

The aged individual has to cope with a multitude of losses that often interact and accumulate in the manner of a vicious circle, at a time when the physical and mental energy needed for effective coping is decreasing. This has two implications. First, the usual ways of coping, especially the high energy defenses, may have to be replaced by new techniques of adaptation. Active or aggressive mastery, for example, may

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67Adrian Verwoerdt, Clinical Geropsychiatry, p. 23.
be replaced by acceptance and the capacity to resign oneself to the inevitable without self-reproach, bitterness, or cynicism.  

The capacity for coping with stress (the range of capacity, and the types of defenses chosen) is a function of the ego. Ego strength determines, to a large extent, the degree of success in coping. When a person overextends himself in his attempts toward mastery, we can speak of a crisis. Whether or not a crisis will be resolved depends, by and large, on the ego's potential for growth; crisis resolution, in turn, results in further ego growth. We can try to assess ego strength by exploring the individual's manner of coping with stress in the past, his mastery of novel situations, as well as the objective signs of achievement and subjective sense of satisfaction with regard to previous life phases (marriage, parenthood, work, etc.).

The range of coping mechanisms is based on a repertoire determined largely by past experiences and relationships to significant people in childhood and young adult life. A person whose earlier life was relatively wholesome and free from major intrapsychic conflicts possesses more flexibility and a greater range of effective behavioral responses to stress, because less effort is expended in dealing with internal (neurotic) pressures. On the other hand, an individual who has always had limited psychological resources and resiliency, and who has managed only a precarious adjustment, is

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more likely to respond maladaptively to stress. The overly independent person, for example, who has always resisted any appearance of weakness may perceive a disabling disease as catastrophic, responding to it in a disorganized fashion, whereas another individual with fewer conflicts may be able to adjust to the same disability more gracefully.

The individual's capacity to adapt successfully is also influenced by organic problems such as mental retardation, congenital or acquired deformities, organic brain damage, and so forth. The person who cannot fully comprehend a problem or who lacks the physical capacity to respond efficiently is clearly limited in his attempts at adaptation.

The aged person's external environment is a very influential factor in the ability to adapt successfully. The ability of a spouse or other family member to move in supportively, when greater physical dependence is unavoidable, will enable the aged person to remain in his environment for a longer time.

Whether coping or defense mechanisms are adaptive or maladaptive depends upon the type and intensity of the defense as well as upon its appropriateness to the situation. Adaptive coping techniques imply a re-establishment of an equilibrium that was disturbed by a loss. In the case of coping with physical illness, for example, adaptive devices presuppose some amount of cognitive awareness regarding the illness, a willingness to seek medical help, and a realistic adjustment to the sick role. Maladaptive defenses aggravate the patient's
suffering, deplete his resources, and weaken his resistance. Maladaptive coping behavior typically leads to a vicious circle which aggravates the very problem against which it is directed. In the language of cybernetics: adaptive coping represents a negative feedback leading to a corrective intervention, whereas maladaptive coping involves a positive feedback leading to a vicious circle. In the latter case, unpleasant emotions and painful tension do not abate, but accumulate in the individual. 69

Although such studies provide encouraging bits of information that are potentially relevant to the study of coping, concerted and integrated efforts to investigate the complex configuration of behaviors and attitudes that comprise coping in late life are clearly needed.

H. Summary

Our purpose has been to examine the literature concerning six of the latest theories of aging which was undertaken with the precise purpose of discovering the questions and implications to which a model of pastoral care for the Institutional Geriatric Church must respond. Of the six areas of aging theory building examined, the primary area selected to be utilized in the dissertation will be the Continuity of Life Theories which emphasize that personality traits are persistent throughout life. There will be overlapping in this

69 Adrian Verwoerdt, Clinical Geropsychiatry, p. 25.
use, of the other five areas of theories: Biological, Disen-
gagement, Activity, Environmental, and Development.

Some questions raised from the study include the
following: (1) What latent personality traits should the el-
derly person possess to respond to change, adaptation to en-
vironment, and a positive growth to God? (2) What coping
skills are needed for change, adaptation to environment, and
a positive growth to God? (3) How may continuity and change
be distinguished between the psychiatric person and the "so
called" normal aging population? (4) Who should be involved
in older adult facilitating processes of the Liberation Min-
istry of the Institutional Geriatric Church?

A primary implication is that the continuation of life
personality processes are consistent with the continuation of
life coping abilities of the older adult. This emergent con-
sistent trend contributes to the selection of Continuity
Theories of Aging for primary use in the dissertation.

This chapter builds a foundation for selection of
relevant materials from the behavioral sciences in the crea-
tion of theological norms for the Liberation Ministry of the
Institutional Geriatric Church. Further insights will be
generated by an examination in the next chapter of the life
quality of geriatric persons residing in the parish of the
Institutional Geriatric Church.
CHAPTER III

THE HOSPITAL SETTING AND PRESENTATION OF THE DATA

A. Introduction

The purpose of this chapter is twofold: (1) in order to better understand the community from which the norms of the dissertation must arise and in order to relate the selected relevant material emerging from the behavioral sciences with the resources of the Institutional Geriatric Church, an examination of the setting in which the project was carried out will be undertaken, and (2) in order to better understand the background of the members of the Bible Study Group and their reactions, the data (case studies and a systematic report of each session of the Bible Study Group) will be presented.

B. A Brief History of Central State Hospital

The first state psychiatric hospital in Georgia was opened a few miles south of Milledgeville on October 12, 1842 (known today as Central State Hospital). By 1964, the resident population census numbered 12,305. In the year 1970, the resident population census numbered less than 10,000. The present census numbers some 2,275.\(^1\) There has been a decrease

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\(^1\) Public Relations/Information Office, "Central State Hospital--Caring for Georgians Since 1842", A Public Information Pamphlet (Milledgeville, Georgia: Central State Hospital, 1983).
of 150,000 Geriatric patients alone in the last five years in State Mental Hospitals.²

Major factors in the decrease of the above census numbers may be reflected in the following important considerations: (1) the establishment of and transfer of patients to regional hospitals, (2) improved patient treatment programs, (3) the establishment of more community mental health programs, and (4) the placement of patients in nursing homes, foster care homes, group homes, and other approved living arrangements.

During the year July 1, 1981, through June 30, 1982, admissions to Central State Hospital totaled 5,057 and included first admissions and readmissions. Total discharges for the same period were 5,109.³

The hospital is contained within an acreage proximity of a little more than one and one-half square miles. Situated within this area there are fourteen patient care buildings, a general hospital, a police department, a fire department, four centers of religious worship (the Chapels of All Faiths), cemeteries, recreational facilities, warehouses, maintenance shops, laundry, steam plants, a central kitchen serving the entire hospital complex (and adjacent Middle Georgia Correctional Center complexes), i.e., preparing and delivering some 15,000 meals a day to its constituents. There are other organizational support departments sustained normally by mental hospitals.


³Public Relations/Information Office, "Central State Hospital".
Central State Hospital presently has eight treatment facilities: the Regional Psychiatric Division, the Forensic Services Division, the Extended Care Adult Psychiatric Division, the Special Care Division, the Medical Surgical Division, the Mental Retardation Division, the Veterans Division, and the Geriatric Division.

In 1975, in order to localize mental health and mental retardation planning and for coordination purposes of hospital and community services, the Mental Health/Mental Retardation Division of the Georgia Department of Human Resources established eight planning consortia.

Central State Hospital is an affiliate of the Central Georgia Mental Health/Mental Retardation Consortium, a group responsible for the planning and deliverance of services to twenty-three counties in Middle Georgia.

C. The Geriatric Division of Central State Hospital

The Geriatric Division provides services to older, long-term care patients from throughout the state with special emphasis placed on designing programs to specifically meet the habilitative needs of the elderly person.

The residents in this division experience an exceptionally high life quality. Their quality of life, which is impacted by education (orientation classes, reality classes, groups conducted by the various disciplines, etc.) is embodied in:

1. **Material and physical well-being**, including financial security, physical and mental fitness, and
health problems. The residents have every material need furnished by the hospital including wearing apparel, television, etc. Even those who have no income occasionally receive monetary gifts from volunteer resources for birthdays, holidays, and other special occasions. The volunteer and activity departments supply them, where needed, with tobacco products, soft drinks, candy, cookies, etc. Daily exercise classes are carried out by the activity department. Every effort is made to maintain and improve mental fitness. Their health is watched over twenty-four hours continually by professional and semi-professionals in the health caring disciplines.

2. Relations with older people—with spouse or other close companions as well as other relatives in the family of origin and the family of procreation, and with friends. Residents receive visitors ranging from relatives in the family of origin and the family of procreation and friends (some often, some seldom, and some never—some have no known relatives). The only family some may ever know may be another geriatric person who has been "adopted" by another as a son, daughter, sister or mother. Others may find their family in the housekeeper, the health service technician, the dining room worker, the secretary, the clinical
chaplain, the shift supervisor, or other staff members. In general, most every resident finds someone to care for sooner or later.

3. Social, community and civic activities which refer to helping activities and participation in voluntary associations, and freedom of participation in, as well as having appreciation for, political, social, and religious activities. There is not much opportunity for the resident to volunteer services to social, community, and civic organizations; however, they are advised of political activities and have the freedom to participate, such as going to the public polls to vote. They have the freedom to participate in religious services unique to their religious creed. Religious participation is one of the more popular activities of the residents. When the announcement is made on the intercom by the clinical chaplain that "it is time now for our regular Wednesday morning church services", many are already prepared to go and are waiting for the announcement. Attendance will usually be between 120 to 160 residents in church. There are some who will go to church and not to other activities. Many are not able to participate for various reasons yet they respond to the "preacher" when he visits them on the ward. Religion is obviously very meaningful to geriatric persons.
4. **Personal development and fulfillment** including intellectual development, a personal understanding and purpose for living, using one's abilities through engagement in interesting, challenging, rewarding, and worthwhile work in a job or at home, and demonstrating creativity and personal expression—ingenuity, originality, and imagination in areas such as the arts. Most disciplines maintain various classes, groups, and individual activities that encourage the above situations and behaviors. Some residents find work in the dining room, some take music lessons, some are active in the Geriatric Division Church Choir and some participate in other activities.

5. **Recreation** which involves socializing, passive and observational recreational activities, and active participatory recreation. This is another area of participation that is more popular. There are regular movies, bingo games, picnics, live music, recorded music played on the wards by the music therapists, volunteer services (garden clubs, monthly birthday parties, etc.) and other activities pertaining to recreation.

The quality of life then, for the resident in the Geriatric Division of the Central State Hospital, is of a superior calibre. Older adults maintaining themselves in houses, apartments, housing projects, other special living
arrangements, and those living in an extended family system, generally speaking, cannot possibly begin to approach this level of life quality. For example, they must face the economy of today's economic situation (the resident's least concern seems to be the economic situation); they do not have teams of various disciplines constantly planning and evaluating, and then planning again systematically for further evaluation, the state of their welfare and well-being; they do not have persons committed to their personal care continuously day and night; they do not have the immediate police security and fire protection that the resident enjoys; and often they cannot get to church or visit the few friends they have left (every resident will see his/her pastor averaging five times a week and there are many peers and staff with whom they can make new friends). Further, they do not have the immediate availability of resources for the solving of health problems, especially in emergencies as does the resident—the "doctor" can be reached momentarily and will quickly come to "the house" to see about his resident. There are other similar reasons why the quality of life for the resident in the Geriatric Division of the Central State Hospital is of a superior calibre.

D. Case Studies of Members of the Bible Study Group

In order to better understand the background of the members of the Bible Study Group, the following data will be presented here.
1. Psychological Evaluation of Case Number One

a. History

Number One was a black, widowed female. Her approximate age range was 69-79. Amount of education and number of children was unknown. She came to Central State Hospital for the first time three years ago.

She was admitted to Central State Hospital with a physician's certificate stating that she was "agitated with paranoid thinking."

A psychiatric examination dated a month earlier described her as cooperative but unable to give very much information about herself. Her memory was impaired and she gave irrelevant answers. Her affect was flat and she was disoriented in time and place.

Progress notes indicated that she was quiet and cooperative. She required supervision with her personal care and at times was confused. Her activities were limited.

Medical reports just after admission indicated that she had generalized arteriosclerosis and was blind in the right eye.

Her diagnosis on admission was Organic Brain Syndrome associated with Cerebral Arteriosclerosis.

b. Clinical Interview

She stated that she never attended school. She said that she was married and had been married twice; her first husband died. She was disoriented in time and place. She thought that she was at home. She stated that her husband
made her angry so she made him leave and she did not know where he was then.

She stated that she believed in God and attended church. When asked what she did for entertainment, she said, "sit here and chew this" (referring to paper).

She did not know the current date, the President of the United States, nor where she was then.

She was a fairly cooperative patient. On one occasion, she refused to go to a classroom to be tested. She was average in physical attractiveness and somewhat overweight. Her verbalizations were irrelevant and incoherent. Her affect was inappropriate. Her insight and memory were impaired. She did not know how long she had been here, where she was, nor her birthdate.

The ward personnel stated that she often cursed, pulled up grass, and collected items such as sticks. At times, she got upset when other patients were loud. She was not able to take care of her personal needs.

c. Test Results

Administration of the WAIS was attempted; however, due to her lack of education and mental status, she was unable to answer questions. Administration of the Slosson and the Bender-Gestalt Psychomotor Test were attempted also, but, because of her mental condition, the results were not valid. She probably had borderline intelligence. She had no history of education or work experience. She was not able to answer questions on the WAIS nor do the Bender-Gestalt Psychomotor Test. Since she
had never been in a mental institution prior to this admission and had been able to function as a wife, the examiner felt she was not retarded.

d. Diagnostic Impression

Psychosis associated with Organic Brain Syndrome.

e. Final Summary and Recommendations

She was a fairly cooperative patient who was poorly oriented in time and place. Several psychological tests were attempted, but because of her lack of education and mental status, she was not able to answer the questions. Her verbalizations were irrelevant and incoherent. Her memory and insight were impaired. She continually talked about her husband leaving her. She seemed to have borderline intelligence by native endowment. It was felt by the examiner that chemotherapy and activity therapy should be continued.

2. Psychological Evaluation of Case Number Two

a. History

Number Two was an approximately 81 year old, divorced or widowed, white female, education unknown, who was first admitted to Central State Hospital three years ago.

She was admitted under judicial hospitalization by a physician's certificate stating, "needs hospitalization for mental disorder." She stated on admission that someone was going to rape and kill her. A psychiatric examination two weeks before admittance to Central State Hospital described her as overtalkative, her affect was inappropriate, and she
was disoriented and confused. Her memory was impaired for past and recent events. Her judgement was impaired and she had no insight into her condition. Her intellect was significantly impaired; she was functioning at a subnormal level caused by her senile brain disease. Progress notes on admission indicated that she was very quiet and needed supervision with her personal care. Recent progress notes indicated that she was friendly and able to talk with others. She participated in assigned activities but required some supervision with her personal needs. Medical reports indicated arteriosclerosis, senile emphysema, hypogonadism, appendectomy, right middle ear deafness, and left auditory nerve deafness. Her diagnosis on admission was Non-Psychotic Organic Brain Syndrome.

b. Clinical Interview

She stated that she stopped school in the 7th grade. She said that she had worked in an operating room of a hospital, in a cotton mill, and in a store. She said that her husband had also worked in a cotton mill.

She stated that she had been married only once. She said that she was married for two years and that she left her husband because he was mean to her and was jealous.

When questioned as to why she was here at the hospital, she said that she came here to see a doctor and decided to stay. She was disoriented in that she neither knew who the President of the United States was, the date, nor the name of the place she was in then. No admissions of hallucinations or delusions were elicited.
She was a friendly and cooperative patient. She was slightly below average in physical attractiveness and looked her stated age. Her verbalizations were relevant. It is uncertain if her memory was impaired due to the limitations of the interview and the inconsistency of the records. Her affect was somewhat flat. Her insight seemed to be impaired; she said that she came here to see a doctor and decided to stay.

The ward personnel stated that she was no trouble on the ward. She did not display any strange mannerisms or verbalizations. She talked with others and had one particular "friend" that she assisted during meals. She was able to take care of her personal needs but required some supervision. She did attend recreational activities, but did not always participate due to her hearing handicap.

c. Test Results

Several psychological tests were attempted (WAIS, WRAT, Bender), but because of her visual and auditory impairments, valid scores were unobtainable. Due to the fact that the patient was able to function as a wife, her work history, and the quality of her verbalizations, it was believed that she probably had dull normal intelligence by native endowment.

d. Diagnostic Impression

Senile Dementia, Mild.

e. Final Summary and Recommendations

She was a friendly and cooperative patient. She was disoriented in time and place. Her affect was flat and her
verbalizations were coherent and relevant. Her insight was impaired; she said that she came here to see a doctor and decided to stay. Due to the limitations of the interview and the inconsistency of the records, it was uncertain whether her memory was impaired. She probably had dull normal intelligence by native endowment. She did not display any strange mannerisms or verbalizations. She sometimes refused to go to an activity, but other than that she was not any problem on the ward. She participated in some activities but was hindered by a hearing problem. It was recommended that chemotherapy and activity therapy be continued.

3. Psychological Evaluation of Case Number Three
a. History

Number Three was a 79 year old, widowed, black female, who was first admitted to Central State Hospital thirteen years ago (educational level unknown).

She was admitted to Central State Hospital with a physician's certificate stating, "psychotic with hallucinations." On admission, she was oriented except for time, had flight of ideas, admitted auditory and visual hallucinations involving the Lord, had ideas of reference and persecution, and had grandiose ideation. A psychiatric examination dated one month earlier indicated that she was delusional, had a flat and somewhat depressed affect, and was oriented to person and place, but not to time. A summary of progress notes for the next three years indicated that she took care of her personal needs, helped on the ward sometimes, and talked with
others. However, she was very demanding, uncooperative at times, not very active, and chronically complained. More recent progress notes taken during the year of the Bible Study Class indicated that she took care of her personal needs, but refused to go to activities, and chronically complained. Her diagnosis on admission was Manic Depressive Reaction, Mixed Type. The somatic diagnosis was degenerative arthritis, hands and knees; arteriosclerotic heart disease; and cataract.

b. Clinical Interview

She stated that she was a widow, that she had a 4th grade education, and that she had worked as a practical nurse most of her life. She further stated that she had been married three times and was childless. Most of her responses were consistent with the records.

When questioned as to whether or not she believed a preacher could heal diseases by laying his hands on you, she stated, "Yes sir, if they are religious and live the right life. I'm a healer myself. I used to do it here but they got mad at me. A woman down there will tell you so...that I healed her. I don't charge them nothing. Yes, sir, a divine healer." She stated that she believed in God and the Bible and that God spoke to her. When asked what God said to her, she replied, "He just tells me to be oh, so holy; to heal the sick, raise the dead, and cast out demons." She stated that she did not hear this at Central State Hospital because she was not "connected" with her church. When asked why she was here at Central State Hospital, she replied, "Well, I got
sick and they sent me here. I had a spell put on me. My cousin put a spell on me to get me here. Just a light spell on my mind. The Lord showed it to me...just a light spell right across here (pointing at forehead). Just enough to get me in here so he could get my house. But I've been all right since I got here. I ain't crazy. They had me sent here. Yes, sir, he put just a light spell on me. The Lord showed it to me."

She was a friendly and cooperative patient. She was above average in physical attractiveness and looked younger than her stated age. Her personal hygiene was good, but she was overweight. She was partially oriented; she knew the name of this hospital and what type of hospital Central State Hospital was, but she did not know the President of the United States, the Governor of Georgia, nor the date (she did know the correct year). Her verbalizations were relevant, but somewhat repetitive in that she excessively referred to religion. Her affect was normal and her memory appeared to be intact. However, her insight appeared to be somewhat defective in that she could not justify the reason for her admission and implied that she was very normal at the present time. She admitted to having had auditory hallucinations as well as delusions of influence.

The ward personnel stated that she was a slight problem on the ward because she would not attend activities willingly and she was very territorial regarding where she sat. It was reported that in the past she would discourage other
patients from going to activities. She constantly placed her hands on the other patients and tried to "heal" them. She did talk to others on the ward and took care of her personal needs very well. During the day, she sat on the porch and talked with others or attended activities.

c. Test Results

Administration of the WAIS produced a Full Scale I.Q. of 82. Such a score placed this individual within the Borderline Range. Due to her marital history and her ability to function as a housewife, practical nurse, and a cook, it was believed that she had dull normal intelligence by native endowment. Administration of the WRAT produced a reading grade level of 6.6, a spelling grade level of 5.2, and an arithmetic grade level of 1.5. On the Bender-Gestalt Psychomotor Test, the patient scored within the Critical Range. This is suggestive of a CNS impairment.

d. Diagnostic Impression

Schizophrenia, Paranoid Type.

e. Final Summary and Recommendation

She was a friendly and cooperative patient who was partially oriented. Her affect was normal and her memory appeared to be intact. However, her insight was somewhat defective. Her verbalizations were relevant, but excessively religious. It is felt that she had dull normal intelligence by native endowment. She had experienced auditory hallucinations and delusions of influence. She had been hospitalized for a total of 13 years, 2 months, and 8 days. She had made
some progress since her admission but, for the most part, her condition had stabilized. It was recommended that chemotherapy and activity therapy be continued.

4. Psychological Evaluation of Case Number Four

a. History

Number Four was a 72 year old, widowed mother of two children, white female, with a 5th grade education, who was first admitted to Central State Hospital 25 years ago. She was admitted after being found locked in her cabin. She claimed that she had not eaten for two weeks; her mind was a complete blank at this time.

She was admitted to Central State Hospital with a Petition for Commission on Lunacy. She was admitted because she had been hearing voices. She sent word to her son that God had pointed His finger at her and she was going to die. A psychiatric examination at that time described her as being overtalkative, silly, suspicious, depressed, and having an increased interest in religion. She was oriented to person and time but disoriented to place. She was functioning at the average level intellectually. Medical reports indicated no serious illnesses, operations, or injuries. Her diagnosis was Depressive Reaction.

She was admitted to Central State Hospital the second time three years later. After six months her diagnosis was changed to Manic Depressive Reaction. Progress notes indicated that she refused to take her medicine and was very delusional about poison being in her food. She was released the next year.
She was admitted the third time 21 years ago and released six months later. There were no records for this time period.

She was admitted the fourth time the next year and released after nine months. Progress notes during this admission indicated that the patient was cooperative, interested in helping others, managed well, and went to all recreational activities.

She was admitted the fifth time fifteen years ago and released three years later. Progress notes two years before indicated that she denied hearing voices or being depressed, was active on the ward, and expressed a desire to go home.

She was admitted the sixth time in two months after her fifth release. The admission note stated that she was re-admitted because she was "shaking too much and couldn't be still." Progress notes indicated that she was a good candidate for a nursing home. She was released at this time, which was six years after being admitted the sixth time.

She was admitted the seventh time the following month. On admission she was fairly oriented to time and place. She had insight and knew that she had a mental illness. Progress notes the next year indicated that she was overtly hostile, delusional, and withdrawn. She was also paranoid and talked to herself. Progress notes five years later indicated that she continued to eat well but at times, when she didn't eat all of her food, she said she was getting too fat. She said Jesus talked to her through thoughts quite frequently and told
her not to do different things. She took care of all her personal needs. Medical reports indicated arteriosclerotic heart disease, sinusitis, dehydration, generalized arteriosclerosis, hiatal hernia, duodenitis, and diverticulum. Her diagnosis was Depressive Neurosis.

b. Clinical Interview

She stated that she stopped school in the 5th grade because she had a child's mind and could not learn much. She stated that she had been married once. She described her marriage as "stormy". She said her husband drank and wouldn't support the family.

She said that she had worked in a department store and in a cigarette factory. She said that she was also a Theology teacher before coming here. She said that she sat at a table and taught and Christ had people all over the world listening to her. She stated that she planned to teach Theology and work in the church when she left the hospital.

She stated that she did believe in God, the Bible, and a life hereafter. She said she believed Christ could heal, but she believed that the preacher was just a "point of contact". She said that Jesus revealed things to her and had been doing this for 25 years. She said that Jesus and the Holy Ghost taught her things other people did not know about the heavenly realm. She stated that Christ was protecting her from a man on television who was trying to get his hands on her. She said that women shouldn't take up time with men. She said Christ didn't want her to talk to any men. She stated,
"Doctors are not fit men to associate with, they are trying to get their hands on me." She also said that Christ had raised her from the dead seven or eight times but that no one else had witnessed this. She said that the devil also talked to her and told her lies.

When questioned as to why she was here at the hospital, she said that she had a child's mind, but that Christ had given her a mature mind two years earlier.

When questioned as to whether there were any acts she felt she had to perform, she said she must do what God told her to do so that He would protect her.

She was a very cooperative and very friendly patient. She was average in physical attractiveness and looked younger than her stated age. Her personal hygiene was good and she was average in weight. She was well oriented; she knew the approximate date, the President of the United States, and the name of the place she was in. Her verbalizations were relevant; however, she continually referred to her religious convictions. Her affect was normal. Her memory appeared to be normal. Her insight was impaired. She realized that her general mental condition had been poor, but was delusional in that she felt Christ had given her a new mind. She displayed paranoid ideation toward men. She said Christ had told her not to speak to them.

The ward personnel stated that she sometimes tried to get out of participating in activities by saying that God told her not to do a particular thing. She was able to take care
of her personal needs. She spent most of her time on the ward reading the Bible. She interacted with the patients and staff.

c. Test Results

Administration of the WAIS produced a Full Scale I.Q. of 85. The examiner felt that the scores were somewhat depressed due to her age and mental condition. By native endowment, she probably had normal intelligence. Administration of the WRAT produced a reading grade level of 11.3, a spelling grade level of 5.8, and an arithmetic grade level of 1.9. On the Bender-Gestalt Psychomotor Test, the patient scored within the Critical Range. This was suggestive of a CNS impairment.

d. Diagnostic Impression

Schizophrenia, Paranoid Type.

e. Final Summary and Recommendations

She was a friendly and cooperative patient who was well oriented. Her affect was normal. Her verbalizations were relevant, but she displayed some paranoid ideation and frequently referred to her delusional religious convictions. Her memory appeared to be normal. Her insight seemed to be impaired. She realized that her general mental condition had been poor, but was delusional in that she felt Christ had given her a new mind. She probably had normal intelligence by native endowment. She spent most of her time on the ward reading the Bible. She sometimes excused herself from activities by saying God told her not to go. She interacted with other patients and staff. It was recommended that chemotherapy and activity therapy be continued.
E. A Systematic Report of Each Session of the Bible Study Group

In order to better understand the reactions of the members of the Bible Study Group, this report is presented.

1. Session Number One

a. Treatment Ward - Before the Move, Date: September 18

Activity:
Bible Study.

Members:
Numbers One, Two, Three, and Four.

Activity Started:
September 18.

Date of Report:
September 18.

Goals for this Session:
Get acquainted, planning and goal setting.

Procedures:
Asked names and interests to determine Bible Study course curriculum.

Description of Session:
Number One did not attend. She did not feel good. She remained on the patio.

Number Two was sick but she was sitting in a chair.
Number Three was sick in bed and remained there.
Number Four was the only member of the group who attended. There were approximately eleven others in attendance who responded to my invitation to participate. Number Four was a very good participant. It was decided to study a parallel of
the Gospels (I was informed after the session that only those persons previously selected by the Treatment Team were allowed to participate in this particular group therapy).

**Progress:**

No progress.

**Future Plans:**

Continue to get acquainted and begin study of the textbook, Gospel Parallels, a study of a synopsis of the first three Gospels of the Revised Standard Version of the Bible, printed in parallel columns for comparison so that the new version might better meet the needs of students.4

**Sessions Missed:**

0

**Members Dropped:**

0

**Members Added:**

0

2. Session Number Two

a. Treatment Ward - Before the Move, Date: September 25

**Activity:**

Bible Study.

**Members:**

Numbers One, Two, Three, and Four.

Activity Started:
Began study of Parable on anxiety: "Take no thought for what you will eat or wear--birds of the field (Lillies of the Valley) neither toil nor store."

Date of Report:
September 26.

Goals for this Session:
Get acquainted, learn interests and apply principles to our lives, past or present.

Procedures:
Asked questions after reading of Parable and asked for interpretations as it applied to them.

Description of Session:

Number One remembered her childhood. She had no anxiety for food and clothing. She liked her chitterlings fried. She mumbled incoherently most of the time.

Number Two rambled most of the time. She talked constantly about her pains. She couldn't read because she needs glasses. She did talk about chitterlings when asked what foods she liked. She talked coherently during this discussion.

Number Three read the Scriptures well. She was appropriate in the discussions. She talked about food and clothing in her early childhood, and how her family had no anxiety about these things. She started the discussion about chitterlings.

Number Four was very coherent and appropriate. She had never had chitterlings but gave her favorite recipe for a
Buttermilk Egg Custard which was well received by everyone in the group.

**Progress:**

Got to know and understand better the backgrounds of the class members and their needs.

**Future Plans:**

To continue getting acquainted and studying the Gospel Parallels.

**Sessions Missed:**

0

**Members Dropped:**

0

**Members Added:**

0

3. Session Number Three

a. Treatment Ward - Before the Move, Date: October 16

**Activity:**

Bible Study.

**Members:**

Numbers One, Two, Three, and Four.

**Activity Started:**

September 16.

**Date of Report:**

September 18.

**Goals for this Session:**

Get acquainted with residents and apply principles learned from the study of Thanksgiving prayer to their lives.
Procedures:

Encourage participation by prayer, discussions of previous Thanksgiving, and things in general to be thankful for.

Description of Session:

Number One regressed today to an earlier stage of life. She had to leave early to "go feed her mule, her cows, her hogs, and cook her dinner." She wondered where "that boy" (her son) was. Her attention span was shorter in comparison with three weeks earlier. She had to leave after 45 minutes.

Number Two was unusually alert. She can't read because she has no glasses. She cannot hear too well and complains of pain in her chest.

Number Three, as usual, was alert. She read, prayed, and was very appropriate in her participation.

Number Four was, as usual, alert. She did not complain of the pains that interfered with her concentration. She had a lot to be thankful for. In speaking of previous Thanksgiving she displayed very good memory: of giving one of her recipes.

Progress:

Got to know backgrounds and interests by discussing the patients' interests. Discovered an inherent fear of moving to another building existed.

Future Plans:

To continue same procedure, get better acquainted, and explore their feelings concerning moving.
Sessi0ns Missed:

Two: September 2-sickness; September 9-Legal Holiday.

Members Dropped:

0

Members Added:

0

4. Session Number Four

a. Treatment Ward - Before the Move, Date: October 23

Activity:

Bible Study.

Members:

Numbers One, Two, Three, and Four.

Activity Started:

September 18.

Date of Report:

October 23.

Goals for this Session:

To apply Abrams move (Genesis 12) to patients' move to another building, to relieve their fears and anxieties about moving to a new place.

Procedures:

Encourage discussion by asking questions.

Description of Session:

Number One was more aware of the present than the past as she was last session. She expressed to qualms about the move and said she was ready. She still mumbles quite a bit. Her attention span was good.
Number Two complained about her pains but expressed no anxiety or fear about moving. She said she was packed and ready to go. She talked fluently about all the deaths in her family—that all her family is dead and she is just waiting and ready for her own death.

Number Three, from the beginning, seemed well adjusted to the move. She said she was already packed (her bags and boxes) and was ready to move to the new place. She also said she was packed and ready to move to an eternal home—"a better home." She asked, "Why is that new, tall, barbed wire fence around our building? It seems like we are in jail now and they're trying to keep us from going home." She was relieved to understand why the new, tall, barbed wire fence was around the building. The reason was that the prison system of Georgia would move into our vacated building as we moved out. For the past two weeks the prison system had been preparing for their movement into this particular building.

Number Four was anxious about moving. She said it was moving from a place she knew to a place she didn't know. Later she seemed comforted. She even expressed a sorrow for people who die and don't have a better place to go to. She then expressed her comfort in moving to the new building.

Progress:

Eased existing fears and anxieties that could be discovered about moving to the new building.
Future Plans:  
To discuss any adjustment problems that may exist concerning the move to the new building.

Sessions Missed:  
Two: October 2-sickness; October 9-Legal Holiday.

Members Dropped:  
0

Members Added:  
0

5. Session Number Five

a. Treatment Ward - After the Move, Date: October 30

Activity:  
Bible Study.

Members:  
Numbers One, Two, Three, and Four.

Activity Started:  
October 10 - Studied the children of Israel's arrival at the Promised Land.

Date of Report:  
October 30.

Goals for this Session:  
To apply the lesson with their arrival at their new home, to help in adjusting to the move.

Procedures:  
Reading, asking questions, discussions.
Description of Session:

Number One was aware of the fact that she had moved. Her thought patterns were more in the present time. She likes it here and had no difficult adjustment problems.

Number Two was used to the old home but has adjusted and likes it here. "There is a good dining room, more room, and just feels better over here." She seems pretty well adjusted.

Number Three liked the new building right away. She had no big adjustment problems. "Better home, cleaner, more cheerful, and better bedroom."

Number Four didn't like it at first. She hated the move. She has adjusted now and likes the new home the best. "It's more cheery, a newer building, has more light, and more space between beds." She has made a good transition.

Progress:

Felt that most adjustment had already been made. They felt even better after discussing the transition.

Future Plans:

To stay on adjustment of residents to their new home.

Sessions Missed:

2

Members Dropped:

0

Members Added:

0
6. Session Number Six

a. Treatment Ward - After the Move, Date: November 6

Activity:

Bible Study.

Members:

Numbers One, Two, Three, and Four.

Activity Started:

Studied *Home Life in the Bible*, concentrated on looking, 1 Kings 17: 8-16.

Date of Report:

November 7.

Goals for this Session:

To continue helping in adjustment of moving to new home, relating to activities of life in new home with life of Biblical persons' routine duties.

Procedures:

Participants reading scriptures pertaining to cooking, discussions, questions, brainstorming.

Description of Session:

This was a hard day for participants; each had some complaint about not feeling well.

Number One did not feel well today—nothing in particular, but just didn't feel well. She was more aware of the activities than last week, but did not participate as much because of her feelings (illness).

Number Two can't seem to hear well today. When asked a question, she responds by talking of going to church and what
she likes about church. She seems to be well adjusted. She
does not participate much. Her heart hurts.

    Number Three's patience was very short. Her arthritis
is acting up. She does not want anyone else to talk, but
loves to read the Bible out loud. She read extensively our
scripture references; seems to be well adjusted.

    Number Four was not feeling good, but very alert and
aware of activities. She read very well, 1 Kings 17: 8-16,
story of widow of Zarephath cooking for Elijah. She responded
best here. She seems to be very well adjusted.

Progress:

    Felt that the residents are all pretty well adjusted
to the move. They were more enthusiastic toward the end.

Future Plans:

    To watch for regression in adjustment of moving to new
home and try to move those affected, forward, if it occurs.

Sessions Missed:

    2

Members Dropped:

    0

Members Added:

    0

7. Session Number Seven

a. Treatment Ward - After the Move, Date: November 13

Activity:

    Bible Study.
Members:

Numbers One, Two, Three, and Four.

Activity Started:

Studied *Home Life in the Bible, Women's Dress and Ornaments*, 1 Timothy 2:9, October 10.

Date of Report:

November 13.

Goals for this Session:

Checking for adjustments of residents in moving to new building.

Procedures:

Participation of reading and discussing scriptures that apply to normal home life; example: some had hair fixed at beauty shop—above scripture speaks of hair.

Description of Session:

Number One was a little off to the reality of the present. She sometimes would be on the subject at first but would start rambling.

Number Two had her hair fixed. Overall, she felt pretty good. She was unusually alert and participated well. She could even hear pretty well.

Number Three had her hair fixed at the beauty parlor. She read several scriptures and discussed them. She was proud of her hair.

Number Four had her hair fixed. She felt better than before. She was alert and read well but not much discussion.
Progress:

They seem to all be getting into the normal routine of living in an accepted place very well.

Future Plans:

To further look for adjustment problems incurred in moving to a new location. Begin process of closure for termination of class.

Sessions Missed:

2

Members Dropped:

0

Members Added:

0

8. Session Number Eight

a. Treatment Ward - After the Move, Date: November 20

Activity:

Bible Study.

Members:

Numbers One, Two, Three, and Four.

Activity Started:


Giving thanks for coming holidays, Thanksgiving then to Christmas.

Date of Report:

November 21.
Goals for this Session:

To help relax patients and watch for adjusting problems to moving to new building.

Procedures:

Asking questions, patients reading, brainstorming.

Description of Session:

Number One was unusually alert and clear in thoughts. She was right on target in discussions. She was feeling good today. She is adjusting very well.

Number Two had a good Thanksgiving spirit. She was not too responsive later; rheumatism and hearing disturbed her toward end. She did not participate in Nativity part.

Number Three loves to read the lesson scriptures and often will read past. She has made a good adjustment.

Number Four did not have too much Thanksgiving spirit but brightened up when asked to read of birth of Jesus. She has made a very good adjustment.

Progress:

All ladies seem to be well adjusted in new environment.

Future Plans:

Watch for adjustment problems, further study of Jesus' birth, continued closure process for end of classes.

Sessions Missed:

2

Members Dropped:

0

Members Added:

0
F. Summary

The examination of the community from which the norms must arise, and presentation of the data on four case studies, were undertaken in this section. It must be emphasized that the caring resources of this community greatly influence the high degree of life quality of the Geriatric person. To better understand this, see Table 1 in the Appendix. In the next chapter, the Bible Study Group will be evaluated.
CHAPTER IV

A THEORETICAL ANALYSIS AND EVALUATION OF THE DATA

A. Introduction

The purposes in this chapter are to analyze the reactions and behavior of members of the Bible Study Group in each session of the curriculum course and to evaluate their elimination of fear to the move to a new building (the change) and their adaption to the new environment (the coping abilities to adjust to the new environment). It may be helpful to repeat a few statements from the last chapter as orientation. As brought out in the last chapter, for any loss (crisis) or stress to become meaningful it must be perceived, registered in the mind, and evaluated through the process of apperception which is a mental scanning process of comparing incoming stimuli and images with those already stored in memory. Moreover, since the fact of a loss cannot be undone by the ego, but it is possible for the ego—through its defensive mechanisms—to try to prevent the loss from reaching conscious awareness, this situation may become more complex when the ego itself is changing as well, as is observed in organic brain syndrome. Reality perception may also be diminished through a process of withdrawal which prevents the individual from feeling the pain.
that would have come with clear awareness of having suffered a loss, a factor that may play a role in the development of senile regression. Further, in a neurosis there is only a mild to moderate impairment of reality testing, whereas in a psychosis the impairment of contact with reality is severe or total. Thus, a psychotic patient may live entirely in a fantasy world. Some aged individuals, for example, withdraw from reality and retreat into their inner self in order to live off their memories. Here, the writer injects a theoretical observation formed during his tenure of serving as clinical chaplain to the geriatric person. Very typical as a sign of a change of mental attitude due to the aging process is the wish to return to everything which was in his/her childhood. The childhood is glorified. That time was wonderful contrary to the present time. That applies to food, with a sudden remembrance of dishes made by mother fifty years ago; by dress which shall approximate the dresses as worn by parents in the distant past; by language which becomes simplified in order to approach the simple language of childhood, adolescence, and precious memories of marriage and parenthood. This is a consistent emergent trend that may be observed in every member of the Bible Study Group as noted especially in Session numbers two, three, and six.

B. Reactions and Behavior of Cases Number One and Two in the Bible Study Class: A Side by Side Theoretical Analysis

Case Numbers One and Two had diagnostic impressions of psychosis associated with organic brain syndrome and disorientation in time and place. To better understand their reactions
and behavior while participating in the class a brief review of organic brain syndrome will follow.

An organic brain syndrome consists of a characteristic symptomatology including impairments of orientation, memory, intellect, and judgement, as well as emotional liability or shallowness. It may be accompanied by disorders of affect and behavior, and the severity of these may be psychotic or non-psychotic. The syndrome may be acute (reversible) or chronic (irreversible brain damage). When secondary to somatic illness, it tends to be reversible; a physical illness may also cause an acute exacerbation of an already existing chronic brain syndrome. Serial episodes of acute brain syndrome often represent a step-like progression of the chronic form.¹

Structural damage to the brain tends to be irreversible because neurons have limited recuperative capacity and do not reproduce. Structural alterations include a loss of neurons, and increase in senile plaques and the amount of neurofibrillary degeneration. Physiologically, there is a reduction in the metabolic activity of the brain.²

In several types of organic brain syndrome, especially senile and presenile dementia, the etiology remains enigmatic. In other instances, e.g. cerebral arteriosclerosis, the etiological factors are less obscure but this does not necessarily enhance the prospects for effective therapy. For example,

¹Adrian Verwoerdt, Clinical Geropsychiatry (Baltimore: The Williams and Wilkins Company, 1976), p. 34.
²Ibid., p. 35.
certain drugs can increase cerebral blood flow under normal conditions but have little or no impact when cerebral atherosclerosis is present.³

1. Session Number One (Before the Move)

Neither attended this session. Both did not feel well and were sitting up in chairs. It may be added here that both had other physical factors affecting their general behavior besides arteriosclerosis. Number One was blind in the right eye and was considerably overweight. Her diagnostic impression was psychosis associated with organic brain syndrome. Number Two had medical reports indicating senile emphysema, hypogonadism, appendectomy, right middle ear deafness, and left auditory nerve deafness. Her diagnostic impression was senile dementia, mild.

2. Session Number Two

Number One remembered her childhood. It is supposed that she had retreated into the world of her memories and quite possibly this was all that she primarily had left in the sense of reality orientation as observed that when she ate it did not matter what it was, but she ate heartily and her main recreation was to "sit here and chew this" (referring to paper). It is certain that in her ethnic, social, and economic traditions she recalled the memories of her childhood when she stated that she "liked her chitterlings fried". It is obvious then that her mother "fried" her chitterlings often. For clarification

purposes it should be observed that the chitterlings are the intestines of the pork-bearing animal commonly called the hog. This meat is not restricted to ethnic societies except in intrinsic religious areas of religious concern, such as Jewish, Moslem, etc., who are forbidden to eat the meat of the "swine". Her orientation might be otherwise contributed to the fact that as a psychotic patient her impairment of contact with reality is severe.

Number Two was coherent in her conversation but she would not follow the agenda. Her major concern was her pains. She did not read because she "needed glasses" which had not been delivered to her at the time of this session (the hospital maintains a Clinic which provides diagnostic, medical, surgical and other aids contributing to a deliverance of maximum eyesight vision). Her coherence can be attributed to the fact that her condition is mild senile dementia. She also enjoyed eating chitterlings which obviously was a food her mother cooked for her as a child when her background is observed.

3. Session Number Three

Number One was enveloped in her memories pertinent to her adult life. She had to leave the class "to go feed her mule, her cows, her hogs, cook her dinner, and wondering where that boy--her son--was." She was excused from the class because she was extremely insistent that she must leave.

Number Two was unusually alert. She could not read her Scriptures because she "had no glasses" (she received her eye-glasses before the sessions were over). She could not hear too
well and complained of pain in her chest. Her physical condition was of major importance to her at this session. She exerted manipulative activity in the class for the "preacher" to help her to get her "glasses". In coping with the stress of faulty eyesight, we may try to assess her ego strength at that particular time by exploring her manner of coping with stress in the past, her mastery of novel situations, as well as the objective signs of achievement and subjective sense of satisfaction with regard to life phases (marriage, work, etc.).

As observed in her clinical interview, she left her husband because he was mean and jealous. This suggests that if she cannot solve the problem she will discard the problem. In the Bible Study Class she was assured that she would receive her "glasses", and she did receive them. As a result, it is ascertained, she remained from that point as a member of the class.

4. Session Number Four

Number One was more aware of the present this week. On the one hand, she was slightly anxious about moving and on the other hand she finally did not care about moving. She was ready to move anytime. She did not read the selected material, or attempt to, yet her attention span was good when others read. She still mumbled quite a bit during the sessions. These continuous mumbling expressions would have no apparent meaning to the reader under normal circumstances, yet the writer concludes from the past examinations that they must be unintelligible mutterings concerning memories of the past and possibly some concerns about death and the future life as brought up by Number Three.
Number Two complained about her pains, which were no doubt very real to her in view of her medical history. She was already packed and ready to move to another building and expressed no anxiety or fear about moving. Here we may observe a consideration of organic brain syndrome, regardless of the intensity. Moving is a crisis to young and old alike. The present problem is not registered in her apperception to the extent that she can realize that a crisis exists.

5. Session Number Five (Just after the Move)

Number One was aware of the fact that she had moved. Her thought patterns were more in the present time. "She likes it here" and had no difficult adjustment problems.

Although there is no conceived problem of a crisis (such as moving) to be registered in cases of diagnosed organic brain syndrome, some statements from the last chapter may be repeated here. For example, it was stated earlier that:

"A substantial amount of research has focused on specific attitudes or personality traits that may be relevant to coping. For example, studies have examined levels of internal versus external locus of control. The findings consistently indicate that older persons exhibit high levels of perceived internal control—higher levels than those of younger persons." 4

Theoretically speaking then, regardless of the fact of organic brain syndrome, there exists within most everyone a continuity of lifelong, built-up coping stances that are often utilized to solve the basic problems of life. The writer's theory is further substantiated as we review the stance of Number Two in this session after moving to a new building.

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4 See p. 54.
Number Two was used to the old home but has adjusted and likes it here. "There is a good dining room, more room, and just feels better over here." She seemed very well adjusted. Number Two certainly must have had a consistent level of conceived internal control; some degree of no recognition of an existing crisis and a recognition of the new environment's contribution to a higher level of life quality and the availability of the many resources to her well-being.

6. Session Number Six

Somehow all participants considered this a hard day. All were sick but none had a particular reason. Everyone had a complaint about not feeling well. Number One just did not feel well, in her words. She was more aware of this week's activities but did not participate as much as last week because of her feelings. She said that she was ill.

Number Two was not able to hear very well. She answered most questions by talking of going to church and what she liked about church. She seemed to be well adjusted but did not participate much. Obviously the physical conditions of each contributed to a slowing down in participation. It is noticeable that there was a substantial amount of reality orientation in both, in spite of their illness and pains.

7. Session Number Seven

We studied home life in the Bible and women's clothing and ornaments of that day.

Number One was a little off to the reality of the present. She sometimes would be on the subject at first but would
start rambling. Even the memories of home life from childhood to adulthood were no retreat for her today, yet she seemed to be trying so hard to be a part of the interaction of the group. She could not respond well to discussions of "her mule, her hogs, her cows, or even her son".

Number Two had the best day since the class started. She received her "glasses" and read well; she had been to the beauty parlor and had a new hair-do; she could hear comparatively well and was unusually alert during very good participation. She never complained about her pains. It is suggestive that her "glasses" and a new hair-do served as tools of coping skills allowing her to assume a good coping stance and a further move toward adaptation to her new environment. Here we may see the quality of life in the hospital serving as a common denominator in the aid to the release of fear and a positive move to adaptation. She seems to be getting into the normal routine of living in an accepted place very well.

8. Session Number Eight

Number One was unusually alert and clear in thoughts. She was right on target in discussions. She was feeling good and adjusting very well. She was more aware of the fact that she had moved. She seemed to look back and was pleased that she lived in "such a good place" now. This was her best day of the duration of the class. She felt some slight remorse about leaving the old place but this disappeared shortly.

Number Two maintained her coping stance of the last session. She had a good Thanksgiving spirit as seen in her
voicing her many thanks for past life, present life, and the assurance of a good future life. Toward the end of the session her rheumatism and hearing disturbed her and her participation was limited from then on.

9. Summary

Both persons suffered from an organic brain syndrome. Number One's syndrome was chronic (irreversible brain damage) and she was psychotic. Number Two's syndrome was acute (reversible) and she was nonpsychotic. Both retreated into childhood memories occasionally; both regressed from, and both were in touch with, reality from time to time in accordance to their diagnosis. Both complained of illness. Both had physical conditions that may have exacerbated the already existing syndromes, yet it was striking to observe that toward the last session both, in their own ways, moved upward on the scales of release of fear and adjustment.

C. Reactions and Behavior of Cases Number Three and Four in the Bible Study Class: A Side by Side Theoretical Analysis

Case Numbers Three and Four had diagnostic impressions of schizophrenia, paranoid type, and they were both partially oriented with normal affect and apparent intact memories. To better understand their reactions and behavior while participating in the class, it is deemed necessary by the writer that additional theory should be added here.

Compared with other forms of schizophrenia, the paranoid type becomes clinically manifest at a later age, usually after age thirty. One plausible factor is that, compared with
other forms of schizophrenia, the paranoid type is relatively less severe. A disorder that, intrinsically or for whatever reasons, is less severe would proportionally need more time to become manifest.\(^5\)

Paranoid schizophrenia may leave the personality relatively intact, in contrast to other types of schizophrenia. The symptomatology includes delusions of persecution or grandeur, ideas of reference, auditory hallucinations and frequent preoccupation with religion or supernatural topics. A distinction is made between a hostile and a grandiose subtype. The **hostile** subtype is characterized by delusions of persecution and injustice, extensive use of projection, a tendency to develop a systematized network of interrelated delusions, and auditory hallucinations of a threatening or violent nature. The **grandiose** subtype has delusions of grandeur and occasional persecutory delusions, autistic restitution fantasies (regression to infantile omnipotence), inclusion of protective supernatural powers in the delusional system, and auditory hallucinations involving communication with the supernatural powers.\(^6\)

This may be observed in Number Three in that "God spoke to her—to be extremely holy, to heal the sick, raise the dead and cast out demons." This may also be observed in Number Four in that "Jesus revealed things to her and had been doing this for twenty-five years; that Jesus and the Holy Ghost taught

\[5\] Adrian Verwoerdt, *Clinical Geropsychiatry*, p. 61.

\[6\] Ibid., p. 64.
her things other people did not know about the heavenly realms and that her task was to teach religion."

The difference between these clinical subtypes probably has little significance. Whenever an individual feels singled out for persecution, it is easy for that person to rationalize that he/she must be special and from here it is only a small step to get on the road toward grandiosity. Conversely, anyone who feels grandiose, extra special, or chosen by God may well conclude that lesser mortals envy him/her. Thus, that person will start imagining that evil elements are ganging up on him/her to get even with him/her, or rob him/her of his/her treasure. Because of the ideas of reference and paranoid delusions, such patients are constantly on the move. This is not entirely true, however, because biological conditions may impair their physical movement. It is observed that even in their wheelchair or their bed of affliction, they will continue in their "call" to carry out the commands of their God, i.e., preaching, teaching, the laying on of hands for healing purposes, etc.

1. Session Number One (Before the Move)

Number Three was sick in bed and remained there. Medical reports gave her somatic diagnosis as degenerative arthritis, hands and knees, arteriosclerotic heart disease and cataract.

Number Four was the only member of the group who attended this first session. She responded very well to group

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7Ibid., p. 64.
interaction and we became fairly well acquainted during this first session. It is striking that she attended because the writer was later informed that it had been a long time since she had carried on a conversation with a male. Medical reports indicated arteriosclerotic heart disease, sinusitis, dehydration, generalized arteriosclerosis, hiatal hernia, duodenitis, and diverticulum. It is the opinion of the writer that somehow she must have found some hope that she might find an ally to her ministry of teaching religion—someone she could trust. This is reflected in the fact that she never missed a session and was always ready and, most of the time, was quite eager to attend. It is suggested that at this session was born a resolution which involved a redirecting of energies and interests toward new people, goals, or activities. We became friends of great respect.

2. Session Number Two

Number Three read the Scriptures well and was appropriate in the discussions. She talked about food and clothing in her early childhood, and how on the farm her father (who incidentally was an African-Methodist-Episcopal minister) had raised enough food and her mother made plenty of clothing for them. She was never anxious about God supplying these needs. She started the discussion about chitterlings. Here we see a retreat to early childhood memories.

Number Four was very coherent and appropriate. She had never had chitterlings but gave her favorite recipe for a buttermilk egg custard which was well received by the group.
This was a custard that her mother had baked for her as a child. She returned to her early childhood memories and also had an opportunity to teach the class in detail. She answered questions about baking the custard and seemed quite pleased.

3. Session Number Three

Number Three, as usual, was alert. She read, prayed, and was very appropriate in her participation. It is felt that she also had "found a trusted ally" for her ministry and an opportunity in the class to freely minister to the group. She never missed another session.

Number Four was, as usual, alert. She did not complain of the pains that often interfered with her concentration. She had a lot to be thankful for. In speaking of previous Thanksgivings she displayed very good memory. She taught the group another recipe and how to prepare it. Obviously, she felt that she at last had a class to teach. She not only taught foods but God's goodness as well. It was at this session that a general fear of moving to another building was discovered by the writer.

4. Session Number Four

Number Three, from the beginning, seemed well adjusted to the move. She said she was already packed (her bags and boxes) and was ready to move to the new place. She also said she was packed and ready to move to an eternal home--"a better home". Then her anxiety surfaced. She asked, "Why is that new, tall, barbed-wire fence around our building? It seems like we are in jail now and they're trying to keep us from
going home." She was relieved to know that the prison system of Georgia would move into our vacated building as we moved out and that for the past two weeks they had been preparing for their movement into this particular building. Her anxiety was not for the movement to another building here, but that she would not be able to go, interestingly enough. The writer had explained that there would be new curtains, more room to move about in, beautiful pictures, etc. It may be added here that all existing fears and anxieties were comfortably eased during this session.

Number Four was anxious about moving. She said it was moving from a place she knew to a place she didn't know. Later she seemed comforted after being reminded of the curriculum study for the day: Abram's move to a place he did not know but that God would go with him and He would go with us as well. Then she expressed a sorrow for people who die and don't have a better place to go to. She then expressed comfort in moving to the new building.

5. Session Number Five (Just after the Move)

Number Three liked the new building right away. She had no big adjustment problems. She said, "This is a better home, cleaner, more cheerful, and better bedrooms." There are two factors to be observed here. The first factor consists of the general problem for the designer on environments for the elderly in how much support and how much challenge should be built into such environments. An overly supportive environment robs the individual of initiative and the opportunity to
exercise his/her adaptive ability, thereby maintaining it and enjoying the consequent sense of mastery and its favorable effect on self-esteem. An overly demanding environment frustrates, discourages, and further lowers competence and self-esteem. The problem of how much support and how much demand to build into living environments so that they will be optimal for older persons is greatly complicated by the diversity of that group at present and the likelihood that it will become even more heterogeneous with time. In our case, we have a homogenous group even though there are two differing diagnostic frames of reference. For everyone it is "a good home, more cheery, better bedrooms, a better place to be, and I like it here." Obviously, the design is consistent with the needs of the group. The second factor is that the life quality of residents of the hospital is consistent with their needs.

Number Four didn't like it at first. She hated the move. She has adjusted now and likes the new home the best. "It's more cheery, a newer building, has more light, and more space between beds." Her adjustment in the last few days is excellent.

6. Session Number Six

This was a bad day for everyone. All complained of illness or not feeling well. Number Three's patience was very short. Her physical condition of arthritis was active, yet she did not want anyone else to talk. She thoroughly enjoyed reading the Bible to the group. She read her assignment and even much more. She seemed well adjusted. She exceptionally
enjoyed reading the story of the widow of Zarepath cooking for Elijah. She obviously misses the occupations of the wife in a family, especially the cooking.

7. Session Number Seven

Number Three had her hair done at the beauty parlor. She read several scriptures and discussed them. She was proud of her hair-do. Here she was proud of her hair as every lady in all circles are when the hair is at its best. She taught her Bible class in the reading of the scriptures and the discussion of them—practicing her ministry.

Number Four had her hair fixed at the beauty parlor. She felt better than before, as she expressed it. She also was alert and read well but offered little discussion. Her physical condition was obviously a primary factor in her quiet attitude. Even then, she did not complain.

8. Session Number Eight

Number Three, it is observed, loves to read the lesson scriptures and more than often will read past her assigned section. She has made a good adjustment. Her primary concern now is to pray, teach, and lay on hands for healing purposes.

Number Four did not have too much Thanksgiving spirit but brightened up when asked to read of the birth of Jesus Christ. She read and taught of His birth to the group. She has made a very good adjustment.

9. Summary

Both persons were diagnosed: schizophrenia, paranoid type. Number Three was the grandiose subtype. Number Four
was the grandiose subtype; however, in past years she had a history of occasional tendencies of the hostile subtype. Both referred to God and religion continuously. Both carried out their "ministries" with other patients, Number Three more so than Number Four. Both retreated into childhood memories occasionally, both had good coping stances, and from the beginning had seemed advanced in their resolution of the impending crisis of moving and had little or no problem in adapting to the new environment.

D. Final Summary

A systematic assessment of members of the Bible Study Group, factors contributing to their reactions and behavior while participating in the sessions, and their coping abilities and stances in relation to the change of environment and adaptation to the change will be presented at this point.

1. Personality Types

Number One was the rocking chair type—the passive-dependent yet unoriented person in that her sense of apperception was highly limited due to her advanced stage of organic brain syndrome. Number Two was also the rocking chair type with a much higher level of apperception. Numbers Three and Four were the armored defended type. They both had highly integrated defense mechanisms that shielded them from the perception of stress.

2. Personality Traits

As brought out in the last chapter, four personality traits are suggested as important elements of coping styles:
chronic anxiety, openness to new experience, impulse control, and a tendency to deny the experience of threat. High levels of chronic anxiety are detrimental to effective coping for a number of reasons. Anxiety is likely to sensitize an individual to the perception of stress, interfere with the appraisal of relevant behavioral alternatives, and hinder an individual's ability to implement behavioral goals. In the Group there were no perceived high levels of anxiety to change. Number One's anxieties only concerned her memories. Number Two was anxious about her "glasses". Numbers Three and Four seemed to have only flighting anxieties. Openness to new experience, which reflects an underlying acceptance of change and a flexible stance toward the environment, facilitates coping. Every member possessed this personality trait considering the differing diagnoses. Poor impulse control is viewed as detrimental to effective coping, because it usually precludes well-planned action that is based on adequate information about the range of behavioral alternatives. In reviewing the condition of the members it cannot be truthfully said that they had poor impulse control as referred to change. Similarly, denial is not viewed as an effective long-range coping response. The prevailing view suggests that the realities of the stressful situation will eventually resurface and that denial will have prohibited the gathering of adequate information on which to base a constructive behavioral plan. It is felt that there was some degree of denial in everyone, even in Number One.
3. Attitudes

Several attitudes are relevant to coping. The most important of these is a sense of self-efficacy—a basic belief in one's ability to initiate and control personal experience. A perception of oneself as an active agent, in control of one's life course, is another component of effective coping. Again, it must be stated that in varying degrees, everyone had this personality trait.

In general then, personality and attitudinal factors appear to operate as predispositions to the likelihood of an active, masterful coping style. Consequently, we would expect these factors to correlate highly with the behavioral coping strategies our members chose when confronting the stressful situation of change. As was stated earlier, very little is known about coping skills in later life; however, there are no compelling reasons to believe that coping styles are strongly related to age. Throughout adulthood, individuals probably develop and refine a repertoire of workable coping strategies that are compatible with their personal dispositions, lifestyles, physical and mental conditions.

As stated before (see page 54), a substantial amount of research has focused on specific attitudes or personality traits that may be relevant to coping. For example, studies have examined levels of internal versus external locus of control. The findings consistently indicate that older persons exhibit high levels of perceived internal control—higher levels than those of younger persons. Since a sense of
self-efficacy is associated with effective coping, this pattern bodes well for the coping stances of most older persons.

4. Beliefs

Beliefs regarding the nature of the world (the external environment) are relevant to effective coping. A sense of basic trust in the world—a perception of the world as an orderly, predictable, and responsive environment—is conducive to effective coping. Conversely, feelings of anomic or distrust hinder an active, organized coping stance. The writer suggests that every member of the Group had this basic trust in the world. It is suggested that Number One had this belief in that her primary concern was to control her memories which she trusted and lived her life as she chose in her fantasy world. Number Two certainly must have had this belief as we remember her manipulative dealings with the "preacher" about her "glasses". Numbers Three and Four obviously must have had this feeling as we recall their strong concern for and practice of their ministries, without regard to how anyone else felt, during their stay in the hospital.

5. Environmental Factors

The aged person's environment is characterized by changes which are stressful in varying degrees (see page 55). Stresses in the external environment include loss of occupation, income, and prestige. In the life quality of the hospital the first two factors are automatically taken care of and, in the case of prestige, an exceptional status may be observed in the patient's quality of life in that many
disciplines' first concern is the welfare and well-being of him/her. Further, there is the opportunity to acquire individual prestige among peers and staff members of the hospital. In the internal milieu, decline in all biological systems is obvious and even here the opportunity abounds. Many of their peers and hospital staff have "fallen in love" with certain individuals because of their personality traits, attitudes, and beliefs, i.e., Number Three has constant testimony of peers that she has or is healing them and the clinical chaplain views all patients as members of his church parish and intrinsically some as a mother, a father, a sister, a brother, a cousin, and most as "little children". The family system of peers, staff, and residents is a prominent spoke in the wheels of the quality of life in this hospital community.

6. The Growth of Ego Strength During the Sessions

Again referring to the last chapter, it has been stated that the capacity for coping with stress (the range of capacity and the types of defenses chosen) is a function of the ego (see page 59). Ego strength determines, to a large extent, the degree of success in coping. When persons overextend themselves in their attempt toward mastery, we can speak of a crisis. Whether or not a crisis will be resolved depends, by and large, on the ego's potential for growth; crisis resolution, in turn, results in further ego growth. We can try to assess ego strength by exploring the individual's manner of coping with stress in the past, his/her mastery of novel situations, as well as the objective signs of achievement and subjective
sense of satisfaction with regard to previous life phases (marriage, parenthood, work, etc.). Number One definitely had ego strength growth. It is observed that she "tried hard" in spite of her illness to interact with the group and in the last session she found her best session. She was unusually alert and clear in thoughts. She seemed to look back and was pleased that she lived in "such a good place now". Number Two no doubt felt that her complaining of her "pains" and the receiving of "her glasses" constituted coping tools for her continuance in the sessions and adaptation to the move. Numbers Three and Four found mastery of their crisis in that they had a group (a congregation or seminary class, if we may) in which to carry on the purposes of their individual ministries of religion. The writer feels that every member of the Group had positive growth of ego strength, a determining factor in their success of coping with change.

E. The Writer's Theoretical Evaluation of the Bible Study Class

In this section the writer will state the criteria for evaluation; the test scales employed for elimination of fear of the movement, for adjustment to the move, and the grading of participants of the Bible Class.

1. Criteria for Evaluation

Suchman proposes five categories of criteria according to which the success or failure of a program may be evaluated. These are: (1) Effort, (2) Performance, (3) Adequacy of
Performance, (4) Efficiency, and (5) Process. A brief summary of these categories will follow.

a. Effort

Evaluations in this category have as their criterion of success the quantity and quality of activity that takes place. This represents an assessment of input or energy regardless of output. It is intended to answer the questions "What did you do?" and "How well did you do it?"

b. Performance

Performance or effect criteria measure the results of effort rather than the effort itself. This requires a clear statement of one's objective. How much is accomplished relative to an immediate goal? Did any change occur? Was the change the one intended?

c. Adequacy of Performance

This criterion of success refers to the degree to which effective performance is adequate to the total amount of need. Thus, a program of intensive psychotherapy for a small group of mentally ill individuals may show highly effective results, but as a public health measure prove thoroughly inadequate to meet the problem of mental illness in an entire community. Adequacy is obviously a relative measure, depending upon how high one sets one's goals.

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9 Ibid., p. 61.
d. Efficiency

A positive answer to the question, "Does it work?" often gives rise to a follow-up question, "Is there any better way to attain the same results?" Efficiency is concerned with the evaluation of alternative paths or methods in terms of costs—in money, time, personnel, and public convenience. In a sense, it represents a ratio between effort and performance—output divided by input.

e. Process

In the course of evaluating the success or failure of a program, a great deal can be learned about how and why a program works or does not work. Strictly speaking, this analysis of the process whereby a program produces the results it does, is not an inherent part of evaluative research. An evaluation study may limit its data collection and analysis simply to determining whether or not a program is successful according to the preceding four criteria without examining the why's and wherefor's of this success or failure. However, an analysis of process can have both administrative and scientific significance, particularly where the evaluation indicates that a program is not working as expected. Locating the cause of the failure may result in modifying the program so that it will work, instead of its being discarded as a complete failure.

For the purposes of the dissertation, criteria number three, Adequacy of Performance, will be the criteria for the evaluation of the Bible Study Group.
2. Test Scale for Eliminating Fear of the Movement
   a. Stated continued fear and stated a refusal to move
   b. Stated continued fear and agreed to move
   c. Fear reduced and refused to move
   d. Fear reduced and was willing to move
   e. Made no difference, move or not to move
   f. Ready to move to new building
   g. Eager to move to new building

3. Test Scale for Adjustment to the Move
   a. Refused to stay in new building
   b. Wanted to go back to old building
   c. Wanted to go back to old building but would stay in new building
   d. Wanted to stay but would go back
   e. Made no difference, to stay or go back
   f. Wanted to stay and liked the environment
   g. Eager to stay in the new building

4. The Grading of Participants of the Bible Class
   a. Eliminating Fear of the Movement (Test Scores on a Scale of A to G)
      Case Study Number One - e; Case Study Number Two - g;
      Case Study Number Three - g; Case Study Number Four - g.
   b. Adjustment to the Move (Test Scores on a Scale of A to G)
      Case Study Number One - f; Case Study Number Two - g;
      Case Study Number Three - g; Case Study Number Four - g.
      Notice the variable of Number One. She received a e score. She did not care whether she moved or not because of
her accelerated condition of organic brain syndrome. The writer's theory here is that she may have received the highest score on another test scoring scale because her coping capacities were not taxed to organize herself for adjustment. She would possibly be happy anywhere that she could enjoy her memories, enjoy the quality of life that she had, and "sit here and chew on this", meaning paper.

F. The Writer's Theoretical Evaluation of a Bible Study Group of Elderly Persons Coping with Change

In conformance with the previously stated selection of criteria for evaluation of the Group, the author presents his final conclusions to meet the concerns of Adequacy of Performance to include the following: (1) a clear statement of the objective, (2) how much was accomplished relative to the immediate goal, (3) did any change occur? (4) was the change the one intended?, and (5) the degree to which effective performance was adequate to the total amount of need (which is the primary demand of the selected criteria for evaluation).

1. The Statement of the Objective

The theoretical objective was to free elderly persons from the fear of movement to another building and to aid in their adjustment to the new environment through the use of Bible Study utilizing their life quality at Central State Hospital as a qualifying factor in these processes.

2. The Amount of Accomplishment Relative to the Immediate Goal

Whatever fear that existed was apparently eliminated. Obviously everyone was adjusted to the change of environment at
the conclusion of the sessions. Therefore, there was, theoretically speaking, a one-hundred percent amount of accomplishment relative to the immediate goal.

3. The Change that Occurred

There was a definite readiness to leave the old building, a general yearning to enter the new building, and an easy and almost immediate adjustment to the new environment.

4. Was the Change the One Intended?

This was the specific change intended.

5. The Degree to which Effective Performance was Adequate to the Total Amount of Need

The writer concludes that there was a one-hundred percent of effective performance adequate to the total amount of need. It is suggested that each member of the Group needed to be accepted totally and unequivocally as an important person who could live freely and according to her personality type, her personality trait, her attitude, her beliefs, and in her own way to increase her personal esteem. Each member further needed a release from any degree of inherent fear from moving from one building to another and a means to adjust to the new environment. The writer herewith concludes that these needs were served and that there was an adequacy of performance to the total needs of the individual and the group in that both, as a whole, responded and performed to the above-mentioned needs.
6. Transitional Statements

In this chapter we have examined theoretical analyses and evaluation of contributing factors to individual reaction and behavior of participants and the group as a whole during the sessions of the Bible Study Group of elderly persons coping with change. Implications for a model of pastoral care for the Institutional Geriatric Church will be drawn from this examination.

The next chapter will examine from the writer's normative theological frame of reference concerning contributing factors of individual and entire group reactions and behavior during this Bible Study Group's sessions for the same purpose as stated above.
CHAPTER V

A NORMATIVE THEOLOGICAL ANALYSIS AND EVALUATION OF THE DATA

A. Introduction

The purposes in this chapter are to analyze the reactions and behavior of members of the Bible Study Group in the sessions of the curriculum course and to evaluate their response to the goal of the Liberation Ministry in the Institutional Geriatric Church. The goal of the Liberation Ministry in this church is the operational theological norm.

The operational theological norm in this dissertation is the liberation of Elderly Persons for a positive growth toward God, the acquisition and/or strengthening of a basic integrity of the life they have lived, a religious commitment to the present and the future, and the building and maintenance of love for self, for contemporaries and for other members of the Institutional Geriatric Church.

In the context of this dissertation, the fear of movement and adaptation to the move not only represents an opportunity for the Elderly Person to experience the saving grace of Jesus Christ (which serves as a period of time when the liberation powers of God can be manifest in their lives), but also as an opportunity for a turning point to occur in their
lives as manifested by their positive growth to God, acquisition and/or strengthening of a basic integrity of the life they have lived, a religious commitment to the present and the future, as well as the building and maintenance of love for self, for contemporaries, and for other members of the Institutional Geriatric Church.

B. The Reactions and Behavior of Case Number One During the Bible Study Class Sessions

There was very little available religious history relating to Number One. She had very few visitors during her first year and none thereafter. She had no known relatives at the time of the sessions. She was unable to give very much information about herself due to her impaired memories and irrelevant answers. Her affect was flat and she was disoriented in time and place. It should be remembered that she had a diagnostic impression of psychosis associated with organic brain syndrome of a very advanced stage. For the above mentioned reasons a very little is known about her religious heritage. In fact, there is only one recorded statement concerning her religious beliefs and practices: "She stated that she believed in God and attended church". To substantiate this statement, it may be added here that she never missed a Wednesday morning church worship service of the Institutional Geriatric Church during the entire session period of the study class. During these church services there was displayed a continuity of her lifelong religious traditions.
From this observation the writer is inclined to believe that her original church affiliation was of the Baptist denomination. Of major importance here it may be suggested that her return to reality was demonstrated primarily during her participation in religious activities. For instance, when the religious songs were played and when we sang them, when the sermons were preached on the stories of the Bible, and especially "when we can remember as children when we went to church with mother" she spontaneously celebrated the worship of God—meaning that even though she could not read she remembered the words of the songs and she remembered the stories of the Bible. She would sometimes stand, clap her hands, and pay tribute to God in her own way. Also, it has been noted in the last chapter that her return to reality was consistent during the Bible Study sessions.

Number One did not attend the first session because "she did not feel good". She attended every session thereafter. In some sessions she regressed from the present and in some she was reality oriented to the present. However, this cannot entirely mean that she was regressed in her religious concerns. It may be ascertained that in every phase of her orientation there was some commitment to her religious beliefs due to her continuous participation in the sessions.

It is interesting to note that she had only three sessions of inappropriate participation in the sessions. These were session numbers one, and especially three and seven. Her
best performances were in five appropriate sessions. These were numbers two, four, five, six, and eight. This emergent consideration will suggest a prominent growth for her concern in the Christian Education processes of the Liberation Ministry of the Institutional Geriatric Church.

1. The Writer's Normative and Theological Evaluation of Case Number One

   In this section the writer will evaluate the response of Number One to the Liberation Ministry in the Institutional Geriatric Church, the goals of which were stated in the introduction of this chapter and the constituent factors of which are presented herewith.

   a. A Positive Growth Toward God

      The writer concludes that there was a positive growth toward God in that Number One continually participated in the sessions when she would not participate in other activities, and that her perceived comfort in life came from the fact that God had not forsaken her in this estranged and final stage of her life.

   b. The Acquisition and/or Strengthening of a Basic Integrity of the Life they have Lived

      Childhood memories made a great contribution toward strengthening the integrity of her past life. It gave her comfort and relieved her anxieties. As we studied the Parable on anxiety in Session Number Two, "Take no thought for what you will eat or wear", the theme is that God will provide your needs in a continual life process. She remembered that she
"liked her chitterlings fried", a delicacy seldom eaten but often sought after by the gourmet of certain social traditions. Due to the expansive time-cost factor in the serving preparation, and the immediate contribution to atherosclerosis, of chitterlings it is highly improbable that she had eaten any during her stay at the hospital. Therefore, we may conclude that her childhood memories of God's provisions for her served as a basic integrity of the life she had lived—for, after all, food must have been one of her primary comforts at this last stage of her life.

c. A Religious Commitment to the Present and the Future
She was religiously committed to the present as noted by her continual participation in the sessions and especially the worship services. Her future religious commitment may be understood in the fact that in her mental and physical condition she "did not care whether she moved or stayed" as she maintained her present religious commitment; thus it may be ascertained that she would be comfortable as she moved to the stage of "eternal life". There was no other stage to enter and it is obvious that she had no despair, or only a minute despair, of her past life.

d. The Building and Maintenance of Love for Self, for Contemporaries, and for Other Members of the Institutional Geriatric Church
Number One responded to this goal of the Liberation Ministry very well in that for self she tried to be more tidy "at church" (moreso here than at Bible Study), she was more
patient with other members of the class, and with other mem-
bers of the church (the staff) she was more consenting to
their requests, such as going to other activities, caring for
her own personal needs, etc.

Number One then, the writer proposes, in her own capa-
city met the criteria for evaluation to score a one-hundred
percent grade in her normative theological analysis and eval-
uation as a member of a Bible Study Group of elderly persons
coping with change.

C. The Reactions and Behavior of Case Number Two
During the Bible Study Class Sessions

There was very little available religious history re-
lating to Number Two. Occasionally, she received visitors.
She was generally overtalkative, her affect was inappropriate,
and she was disoriented and confused. Her memory was impaired
and she had no insight into her condition. Her intellect was
significantly impaired and she was functioning at a subnormal
level caused by her senile brain disease (organic brain syn-
drome). For these reasons little is known about her religious
background. She always attended the Wednesday morning worship
services of the Institutional Geriatric Church. She seemed to
strain to hear the sermons due to a disease of deafness, so
she was usually seated in the front. She sang the songs of
the service as though she could perceive more clearly the
music. She always looked forward to coming to church and once,
during a pastoral visit, stated that she was a Baptist. She
never complained about her "glasses" during worship services
as she did during the Bible Study sessions.
Number Two did not attend the first session because she said that she was sick. In session number two she enjoyed talking about her childhood and how much she liked chitterlings. She had no anxiety about food or clothing and never had. In these sessions she constantly complained about her pains and her "glasses" and that she could not hear well, yet she was ready to come and seemed to find comfort in talking about the studies of the Bible. In session three she complained about her pains but seemed to find new life when the discussion centered on anxiety and fear about moving. She was already packed and ready to move, and fluently and inspiringingly talked about the fact that she was ready to move to a heavenly home. She talked about all the deaths of her family and how she yearned to see them again when she died. She adjusted almost immediately to her new environment in the new building in session five. In session six her every answer to questions was about church. She talked constantly about going to church and what she liked about church, both as a child and at the present. In session number seven she was at her best as far as her happiness was concerned. She had been to the beauty parlor, she had received her "glasses", and could hear much better. In session eight she was thankful, to a high degree, for God's blessings to her.

1. The Writer's Normative and Theological Evaluation of Case Number Two

Here we will evaluate the response of Number Two to the Liberation Ministry in the Institutional Geriatric Church.
a. A Positive Growth Toward God

The writer offers his conclusion: there was a definite positive growth toward God. This conclusion is substantiated in that regardless of her pains, no "glasses", and no "hearing" she always was ready and on time for class sessions and church worship services; further, she clearly recognized the fact that God was with her in her childhood, at the present, and would be with her in eternity.

b. The Acquisition and/or Strengthening of a Basic Integrity of the Life they have Lived

For a better understanding of this section it may be helpful for the reader to refer to page forty of this dissertation concerning Erikson as the writer quotes here directly from one of his published works.¹ This quote is concerned with the geriatric stage of life, the last stage of life, if we may so harshly put it. This last stage is called the eighth age of man by Erikson. In this eighth age there exists a dichotomy of ego integrity and despair. The quote is as follows:

"Ego integrity comes only to the elderly who in some way has taken care of things and people and has adapted himself to the triumphs and disappointments adherent to being, the originator of others or the generator of products and ideas, only in that person may gradually ripen the fruit of these seven stages. In a final consolidation of these ego adaptations death loses its sting. The lack or loss of these accrued ego integration is signified by fear of death: the one and only life cycle is not accepted as the ultimate of life. Despair expresses the feeling that the time is now short, too short for the attempt to start another life and try out alternate roads to integrity. Disgust hides despair.

Each individual, to become a mature adult, must to a sufficient degree develop all the ego qualities so that a wise Indian, a true gentleman, and a mature peasant share and recognize in one another the final stage of integrity.\(^1\)

It is obvious that ego integrity or a basic integrity of the life that she had lived was present in Number Two (it should be recalled that her organic brain syndrome was reversible and its effect was relatively mild). She displayed no fear of death but rather a calm acceptance and a type of anticipation of her eternal life.

c. A Religious Commitment to the Present and the Future

Regardless of Number Two's pains and discomforts, she remained committed to her continual church worship and her Bible Study. She further increased her concern for religious matters toward the end of the sessions and definitely stated her concern for "an eternal life".

d. The Building and Maintenance of Love for Self, for Contemporaries, and for Other Members of the Institutional Geriatric Church

Number Two's response to this goal of the Liberation Ministry in the Geriatric Church was very good. The growth of love for herself was manifest in the seventh session when her self-esteem was heightened due to the quality of life at the hospital which offered her an opportunity to visit the beauty parlor and to receive her eye glasses (it has been previously suggested that the high quality of life that residents enjoy may serve as a common denominator in the high scoring they receive on evaluations). Communication may be aided here if

\(^2\)Ibid., p. 269.
we recall an earlier statement in this dissertation which is as follows:

Pastoral care then, for the purpose of this study, further means bringing to bear upon the elderly, the total caring resources of the institution emphasizing Bible Study induced by their quality of life which serves as a catalytic agent for bringing about the release from fear, the aid to adjustment, the experience of the grace of God, and a positive growth of the members of the Bible Study Group to God.\(^3\)

Her growth of love for contemporaries and for other members of the Institutional Geriatric Church is displayed in her loss of impatience with class members and her increased interest in staff requests to participate in other activities (though she already was a good participant in other activities) and to follow their requests to better care for her own personal needs.

D. The Reactions and Behavior of Case Number Three During the Bible Study Class Sessions

Since childhood Number Three had been a member of the African-Methodist-Episcopal Church (of which her father had been a minister). On a pastoral visit she stated that her father taught his children first and the church second. When questioned as to whether or not she believed a preacher could heal diseases by the laying on of hands, she immediately said that she did if he lived the right life and that she was a healer herself. She had several people who testified that she had healed them. She stated that she believed in God and the Bible, and that in the past God had told her to be very, very holy, to heal the sick, raise the dead, and cast out demons. The ward personnel stated that she was a slight problem.

\(^3\)See p. 7.
on the ward because she would not attend activities well and that she would discourage other patients from going to activities. Her diagnosis was schizophrenia, paranoid, the grandiose type. She was said to be very territorial regarding where she sat on the porch.

Number Three did not attend the first session. She was sick in bed and remained there; however, she attended every session thereafter. She also never missed the Wednesday morning church service in the Institutional Geriatric Church. In fact, she began to bring others with her to the worship services. In session number two she read the scriptures very well and was appropriate in the discussions. She talked about food and clothing in her early childhood and how her father had provided for them. She started the conversation about chitterlings. She read, prayed, and discussed topics appropriately in all sessions. She was always ready to attend when the time came. She loved to read. She would often continue reading to the group past her assigned scripture to read. She was always ready to attend when the time came. She said she felt that God was with her as a child, with her now, and she was packed and ready to leave the old building and was also ready to move to her eternal home. She told us how her father had called the family around his dying bed and told them that he was going to a better home. She started the discussion on the eternal home. She said that God was with her in the new building. She obviously had no problem in adjustment.
1. The Writer's Normative and Theological Evaluation of Case Number Three

Here we will evaluate the response of Number Three to the Liberation Ministry in the Institutional Geriatric Church.

a. A Positive Growth Toward God

The writer concludes that she must have had a positive growth toward God. This may be seen in that before the sessions she would hardly attend other activities and would discourage others from attending activities. She never missed a study session or a church service, and she even began to bring others with her. She further affirmed God's presence with her all her life and would be with her when she goes to a better home in heaven. This is a continuity of life, theologically speaking.

b. The Acquisition and/or Strengthening of a Basic Integrity of the Life they have Lived

Number Three evidently had a large degree of ego integrity. She was pleased with the life she had lived, her past sins had been forgiven, so she felt no despair but anticipation of "going to a better home" with Jesus Christ and her family who had already passed away. It is certain that she acquired and strengthened a basic integrity of the life she had lived.

c. A Religious Commitment to the Present and the Future

For a positive religious commitment to the present she began attending church services and other activities. She stated earlier that she was not "connected" with her church
as the reason she had not heard from God since she had been in the hospital. It is recommended here that she found a church that she could become "connected" with (meaning belonging to as a member), and a church that could fill her religious needs. Her church was now the Institutional Geriatric Church and quite possibly is the only church she will know until her death. Her future commitment can be seen in her considered anticipation of the new life to come in heaven.

d. The Building and Maintenance of Love for Self, for Contemporaries, and for Other Members of the Institutional Geriatric Church

Number Three's response to this goal of the Liberation Ministry in the Institutional Geriatric Church was of excellent calibre. It is to be noticed that she began to encourage others to accompany her to church services, she was less territorial in where she sat and often shared her chair, her esteem for herself was increased when she could feel free to read and discuss and worship God in her own way. She was less demanding and was more cooperative with the staff.

Therefore, her evaluation is stated as a one-hundred percent grade.

E. The Reactions and Behavior of Case Number Four During the Bible Study Class Sessions

Number Four stated that she did believe in God, the Bible, and a life hereafter. She said she believed that Christ could heal and that the preacher was a "point of contact" for healing. She said that Jesus and the Holy Ghost taught her things other people did not know about the heavenly realm.
She stated that Christ was protecting her from a man on television who was trying to get his hands on her and that women should not take up time with men. She further stated that Christ did not want her to talk to any men. She also said that she must do what God told her to do so that He would protect her. Number Four, with all her physical ailments, would not even talk to a medical doctor. Her affect was normal, her memory appeared to be normal, her insight was impaired, and she was well oriented. Her diagnosis was schizophrenia, paranoid, grandiose type.

Number Four never missed a single session of the Bible Study Group or worship services on Wednesday morning of the Institutional Geriatric Church. She was the only member of the group who had not eaten chitterlings, but she taught the class how to bake a buttermilk egg custard. She was basically always coherent, alert, and appropriate as she read, discussed scripture, and in her general interaction with the group. She often wanted to teach, possibly because her religious conviction was to teach here and in a seminary when she was discharged from the hospital. At one time during the session she refused to eat her meals. She said, "Christ told me the food was poisoned." The writer was called to offer pastoral consultation since she would not talk to anyone else during this period. After being reminded that even Christ ate with Martha and Mary and needed to eat so that He would not prematurely die, she asked her "minister" to eat with her. After the writer ate first, with no apparent harm, she then proceeded to
eat and continued to eat during the rest of the period of the Bible Study. It is believed that the writer served for her as a "point of contact" with God on this and several other occasions.

1. The Writer's Normative and Theological Evaluation of Case Number Four

Here the writer offers an evaluation of the response of Number Four to the Liberation Ministry in the Institutional Geriatric Church.

a. A Positive Growth Toward God

The writer's conclusive statement is that there was a superior response to this goal of the Liberation Ministry in the Institutional Geriatric Church. To substantiate this conclusion, it is suggested that it is highly probable that she had a strong feeling that God had not deserted her in this final stage of life in that He had sent a "point of contact" to her even though it was a man. She must have felt that somehow her "minister" was a genuine representative of God. As a result, she had a positive growth toward God.

b. The Acquisition and/or Strengthening of a Basic Integrity of the Life they have Lived

The only despair in the past life that Number Four stated was the husband who drank and would not support his family, even though she felt in her own way that God had compensated for this in that He would be her husband in times of her need. She felt forgiven from all her past sins and had no further despair or fear of moving from this world to a better home. In session number four she expressed verbally a sorrow
for "people who die and do not have a better place to go to."

Her ego integrity was well integrated.

c. A Religious Commitment to the Present and the Future

Her commitments here may be observed in her continued commitment to the interaction of the Bible Study Group and the Wednesday morning church service. The future commitment is seen in her obvious ego integrity in this last stage of her life.

d. The Building and Maintenance of Love for Self, for Contemporaries, and for Other Members of the Institutional Geriatric Church

Number Four's response to this goal of the Liberation Ministry in the Institutional Geriatric Church was superior. A love for herself may be observed when she found a "point of contact" to help her to see that she must obey God's physical laws to survive in this world. She was always kind and helpful to contemporaries but her interest in them increased during the sessions. She offered her skills in teaching theology and practical religion to members and non-members of the class. It was especially striking to notice her growth in love to other members of the Institutional Geriatric Church: she began talking to her medical doctor, the male members of the staff, and began to cooperate with the requests of the staff as a whole.

The writer offers her a one-hundred and ten percentage score here.
F. Summary

In this chapter we have examined the writer's normative theological analyses and evaluation of contributing factors to individual reaction and behavior and their response to the Liberation Ministry in the Institutional Geriatric Church during the sessions of the Bible Study Group of elderly persons coping with change. Implications for a model of pastoral care for the Institutional Geriatric Church will be drawn from this examination.

In the next chapter, a model of pastoral care for the Institutional Geriatric Church will be constructed.
CHAPTER VI

A PASTORAL CARE MODEL FOR THE INSTITUTIONAL GERIATRIC CHURCH

A. Introduction

The purpose of this chapter is to develop the model of pastoral care for the Institutional Geriatric Church. To accomplish this purpose the theological norms of the dissertation will be correlated with the norms of theories on aging.

B. The Theological Method of Correlation

For purposes of this dissertation, the method of correlation consists of the analysis of common data from a theological perspective and a theoretical perspective from the behavioral sciences from which implications are to be drawn for the Liberation Ministry to older adults facing change; more specifically, the model of pastoral care will be developed by examining what the differing frames of reference have to say to each other analogously as a result of their analysis of common data.

C. The Theological Norms of Geriatric Pastoral Care

The norms of this dissertation are shared creations, emerging as the result of the Institutional Geriatric Church's encounter with the revelation of God in Jesus Christ. This encounter was and is with the God of history who became involved
in the geriatric person's struggle for liberation from existential estrangement.

The Christ who brought liberation to mankind is the foundational norm of this dissertation. The Liberation Ministry of the Institutional Geriatric Church is built upon this norm and is the foundational norm of the model of pastoral care.

As stated previously, the Liberation Ministry of this church involves the recognition and release of potential in persons to act on life possibilities in present and future life in spite of limitations. Such liberation means a clarified perception of the state of being of the resident; a relief or deliverance from sorrow, suffering or trouble; and a movement of the capability of the individual resident toward the development into actuality, the release from fear, the aid to adjustment, the experience of the grace of God, and a positive growth to God.

In the Liberation Ministry of the Institutional Geriatric Church the source of all growth potential is God. It is through God's power manifest in Jesus Christ that the residents' capacity to adjust themselves to their current situation is released and through His power that their ability to make a religious commitment is actuated. It is through the power of God to influence the growth of the resident in a positive way. It is also through God's power that the resident gives up the obvious crippling self-image and is restored to an essential nature with God.
In a restatement of the goal of the Liberation Ministry in this church, we must be reminded that the goal is the operational theological norm. The operational theological norm in this dissertation is the liberation of Elderly Persons for a positive growth toward God, the acquisition and/or strengthening of a basic integrity of the life they have lived, a religious commitment to the present and the future, and the building and maintenance of love for self, for contemporaries, and for other members of the Institutional Geriatric Church.

When there is a positive response of the geriatric member of this church to the goal of the Liberation Ministry it may be ascertained that this person has experienced the saving grace of Jesus Christ and can manifest the liberation powers of God, which may be observed in a turning point in their lives when there is a positive growth to God, acquisition and/or strengthening of a basic integrity of the life they have lived, a religious commitment to the present and the future, and the building and maintenance of love for self, for contemporaries, and for other members of the Institutional Geriatric Church.

D. The Theoretical Norms of Geriatric Pastoral Care

In our exploration of Theories on Aging we have examined six theories on aging, each of which has impinging norms upon the geriatric person. A brief review of these is as follows:
1. **Activity Theory of Aging.** The norms here do not markedly change; he is still expected to do much the same as he did in the middle years, with the exception that he is allowed not to work (whether he wants to or not) and is expected to "slow down a little." The sources of satisfaction, his self-concept, and life styles are not expected to change much from what they were in his middle years.

2. **Disengagement Theory of Aging.** The norm in this section is seen as a mutual and inevitable "dis-engaging" of the individual and society. The individual gradually withdraws socially as well as psychologically from his environment into old age. Most importantly, the process of withdrawal is suggested to be mutually satisfying.

For a clear indication to the limitations of these two theories see page 34 of this dissertation as Neugarten states that:

"people, as they grow old, seem to be neither at the mercy of the social environment nor at the mercy of some set intrinsic processes that they cannot influence. On the contrary, the individual seems to continue to make his own "impress" upon the wide range of social and biological changes. He continues to exercise choice and to select from the environment in accordance with his own long-established needs. He ages according to a pattern that has a long history and that maintains itself with adaptation to the end of life."\(^1\)

Here she implies an existence of continuity of life in Geriatrics.

3. **Biological Theories of Aging.** The norms in this area suggest that there are certain inherent changes in the physiological structures in people which occur with aging that may impair their reactions, behavior and function in society but often these reactions, behavior and functions in society may be modified by applications of the behavioral sciences, i.e., medicine, other therapy, etc.

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4. Environmental Theories of Aging. Conceptual models which summarize research on person-environment interaction offer a norm that older persons are more critically affected than younger persons by their living environment, and that with increasing age living environments should be increasingly supportive.

5. Developmental Theories of Aging. In developmental theories of aging the impinging norm is the proper selection of coping skills according to the investment of lifelong personality traits to meet the demands of the various stages of life.

6. Continuity Theories of Aging (the usage of which is a primary concern of this dissertation). These theories are basically personality theories. Personality theories have been chiefly concerned with extending continuities through time. The very concept of personality assumes a continuity in time over the course of life. In the scope of this dissertation the extending of continuities of time is involved with a lifelong buildup of personality traits, attitudes, and beliefs, all of which are relevant to a lifelong buildup of expeditious coping stances in relation to change and adjustment.

E. Geriatric Pastoral Care and Theories on Aging: Implications

Pastoral care is a communal concept. It exists whenever persons minister to one another in the name of God. In this light, pastoral care is not a new concept but has its theological roots in the Judeo-Christian tradition.\(^2\) Pastoral care then, for purposes of this study, further means bringing to bear upon geriatric persons the total caring resources of Central State Hospital, emphasizing Bible Study induced by their quality of life which serves as a catalytic agent for bringing about a positive response to the previously stated goals of the Liberation Ministry in the Institutional Geriatric Church. Here we

find a particular emphasis upon the sustaining function of pastoral care. The sustaining function (which may be symbolized with life quality) serves as a helper for the geriatric person to cope, adjust and grow in love to God, and meet the other goals of the Liberation Ministry in this church.

To assist communication in this area, a brief review of literature concerning the entire functional process of pastoral care may be helpful at this point. Wimberly cites four functions that have characterized the way pastoral care has been practiced in the history of the Christian ministry. These four functions are healing, sustaining, guiding, and reconciling. The review is as follows:

"Healing consists of binding up the wounds; repairing damage that has been done as the result of disease, infection, or invasion; and restoring a condition that has been lost. Sustaining refers to helping persons courageously and creatively endure and transcend difficult situations while preventing or lessening the impact of the situation. Guiding seeks to help persons in trouble make confident choices between alternative courses of action that will help them solve the problems they are facing. Reconciliation seeks to reestablish broken relationships between a person and God on the one hand, and between a person and other persons on the other."

1. The Correctional Process

For purposes of this dissertation the correlation is made between geriatric pastoral care, theories of aging, and the total caring resources of the Institutional Geriatric Church with a special emphasis upon the life quality of the geriatric person. To be more specific, we are seeking to find what each of the three areas have to say to each other. This

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3Ibid., pp. 18-19.
examination will contribute to the actual construction of the model of pastoral care for the Institutional Geriatric Church.

Diagram of Correlation (Figure 1)

<table>
<thead>
<tr>
<th>Geriatric Pastoral Care</th>
<th>Behavioral Sciences</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. God as the source of all growth potential</td>
<td>1. Emphasis on spiritual resources</td>
</tr>
<tr>
<td>2. Healing</td>
<td>2. The systematic concern of the treatment team (the physician, nursing services, the clinical psychologist, etc.) and other support services of the hospital</td>
</tr>
<tr>
<td>3. Sustaining</td>
<td>3. The various disciplines' support of geriatric persons during the crisis of their last stage of life</td>
</tr>
<tr>
<td>4. Guiding</td>
<td>4. The various disciplines' active problem solving activities to geriatric persons</td>
</tr>
<tr>
<td>5. Reconciliation</td>
<td>5. The various disciplines' efforts to reestablish broken relationships between geriatric person, family, friends, and other persons</td>
</tr>
<tr>
<td>7. Using the total caring resources of the Institutional Geriatric Church</td>
<td>7. Using the total clinical resources of Central State Hospital</td>
</tr>
<tr>
<td>8. Diagnosis of problems and tasks</td>
<td>8. Diagnosis of problems and tasks</td>
</tr>
<tr>
<td>9. A continuation of life activity, i.e., &quot;going to church&quot;--attending worship services, Bible study, pastoral fishing trips, etc.</td>
<td>9. A continuation of life activity, i.e., movies, picnics, shopping trips, baseball games, fishing trips, etc.</td>
</tr>
</tbody>
</table>
10. **Continuity of lifelong religious traditions:** the Heilsgeschichte, meaning here a lifelong history of God's salvation of the Geriatric person to serve the buildup of positive crisis resolution techniques through birth, adolescence, marriage, parenthood, old age, and death.

11. **God as the source of all needs of the geriatric person:** "And my God will supply every need of yours according to his riches in glory in Christ Jesus."  

12. **Emphasis on Education**

As may be observed in the above chart, there is some correspondence between geriatric pastoral care, theories of aging, and the total caring resources of the Institutional Geriatric Church with a special emphasis upon the life quality of the geriatric person. According to the diagram, we may ascertain that the above-mentioned three areas may form a central criteria towards the ends of geriatric pastoral care.

The model of pastoral care for the Institutional Geriatric Church will emerge from the clinical chaplain's traditional geriatric pastoral care and will borrow from theories of aging and the total caring resources of the Institutional Geriatric Church to form a new basis of pastoral care toward serving the ends of the Liberation Ministry in this church.

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4 Philippians 4:19 (RSV).
Figure 2. A Model for Pastoral Care in the Institutional Geriatric Church.
The diagram in the proposed model of Pastoral Care for the Institutional Geriatric Church is designed to emphasize three primary areas in which pastoral care in the Liberation Ministry will take place. These three are: (1) Church Worship Services, (2) Nurture, and (3) Care.

F. Church Worship Services

The writer's contention is that the geriatric person's response to church worship service is the foundational genesis for his/her positive growth to God. This may be observed in the fact that geriatric persons whose mental capacities have become extremely deteriorated often pray the coherent and inspiring prayer that brings absolute silence, tears and resolution to many of the church congregation for acknowledgement in later testimony that they know that God has not forsaken them in this last stage of life, and that they have a God who they can depend on in this present estranged stage of life. It is further contended that a sense of reality is felt by the congregation when the liturgurgical worship period is prayer. Moreover, it is felt that this particular sense of reality is conditioned by the members' faithfulness in prayer dispersed. Prayer is a total dimension of the life of the koinonia. Only as the congregation has performed its duty to confess, give thanks, and intercede when dispersed can its prayer be real when it gathers. In this respect the people's action of prayer simultaneously sustains the Church and is sustained by the Church. The Christian man both prays for and is prayed.
for. The prayers of the individual influence the prayer of the Church, and the prayer of the Church affects the prayers of the individual. In an ultimate sense the prayer of the koinonia is part of the prayer of Christ himself. His words at the tomb of Lazarus, "thou hearest me always," may be figuratively interpreted to mean that our prayer is not our own; it is part of the eternal, living intercession of our Lord himself. Here we can see God's liberating powers through Jesus Christ as He constrains us in prayer in spite of our limitations.

As well, when hymns and gospel songs are sung, there are persons who have not spoken and who have been hostile in their behavior, for weeks at a time, who appear to be genuinely happy and some ecstatically so as they celebrate spontaneously their remembrance of the developmental times when they attended church, especially when they went with "mother" as little children. Most do not use hymnals, yet they seemingly remember every word. The elderly seem to find peace, at least temporarily, when they sing the songs of the church.

This same condition exists in practically every area of liturgy in worship service in the Institutional Geriatric Church; therefore, it can be ascertained that without worship

5 Dietrich Bonhoeffer writes: "The first condition, which makes it possible for an individual to pray for the group, is the intercession of all the others for him and his prayer. How could one person pray the prayer of the fellowship without being steadied and upheld in prayer by the fellowship itself?" Life Together, translated by John W. Doberstein (New York: Harper and Brothers, 1954), p. 63.
there can be no church for long. Worship demonstrates God's action to us in the life, death, and resurrection of Jesus Christ and continually reminds the congregation of what He has done for us and what He continues to do for us when we find ourselves facing insurmountable problems of life.

Worship then may be seen as a celebration of liberation in this model.

G. Nurture

We have seen the portrayal of God's active participation in church worship services serving as an aid to our positive growth to Him. God's participation in this manner must also be recognized as a concrete reality of His day-to-day participation in our lives. This divine concern may be translated into the next dimension of the Liberation Ministry of the Institutional Geriatric Church which is Nurture. In the context of this model the functional concern is two-fold: (1) to educate geriatric persons, and (2) to further the development of their response to the goals of the Liberation Ministry in the church.

It may be well to recall the words of Wimberly (from pages 10-11 of this dissertation) concerning the importance of lifelong education as she emphasized that education is a fundamental source of knowledge and understanding:

"To this degree, education serves as a principle modifier of attitudes, behavior, and skills—a process which should be ongoing."6

She further suggests a process of "...learning, unlearning, and relearning; as well as learning to learn and, upon learning, to want to learn." The involvement of older adults in this process is seen as an alternative to apathy, the consequences of which are withdrawal from life and the preclusion of possibilities for self-renewal.7

To further assist our understanding here it is suggested that the reader refer to the writer's footnote (10) on page 10. To summarize briefly it is stated that education has a therapeutic aspect that makes it compatible with pastoral care in the Institutional Geriatric Church. In referring to the Bible Study Group it was brought out that when a situation is thoroughly understood and when there is something that we can do about it, it ceases to be so fearful. Knowledge dissipates enshrouding fear which hampers happiness similarly as radar enables us to "see" through the obscurity of fog, darkness, or storm. Education serves in like manner to adjustment.

This correlation presents a clear implication that education has a therapeutic aspect that makes it compatible with pastoral care in the Institutional Geriatric Church.

Theologically speaking, in reference to the Bible Study Group, we may understand the opportunity they had to experience the saving grace of Jesus Christ and observe the working process of the liberating powers of God as manifested in their lives as they responded to the goals of the Liberation Ministry. Moreover, God's participation in this manner must also be recognized as a concrete reality of His day-to-day participation in our lives.

7Ibid., p. 16-17.
It is suggested here that when proper education curriculum planning processes and when proper teaching methods are employed (the first function of education in Nurture as seen in the model), the development of response to the goals of the Liberation Ministry will almost certainly follow (the second function of education in Nurture as seen in the model).

H. Care

Another dimension of translating God's concern for geriatric persons in their day-to-day lives in the Institutional Geriatric Church is care. In the context of this dissertation, care in the proposed model is concerned primarily with bringing to bear upon the elderly, the total caring resources of Central State Hospital. For a better understanding of this section it may be well to restate Wimberly's definition of pastoral care as see on page six of this study:

"Pastoral care refers to the total ministry of the religious community to individuals and families in crisis."\(^8\)

The religious community in the model is the Institutional Geriatric Church which is the Geriatrics Division of the hospital. This religious community is a part of a larger community body which is Central State Hospital. We are utilizing not only the resources of the Geriatrics Division but also the additional total resources of Central State Hospital. We are further utilizing the resources of an even larger

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\(^8\) Edward P. Wimberly, "A Conceptual Model for Pastoral Care in the Black Church Utilizing Systems and Crisis Theories" (Ph.D. dissertation, Boston University, 1976), p. 3.
community: the Sovereign State of Georgia. One specific example of this may be seen in a recent newspaper article concerning geriatric members of the Institutional Geriatric Church, the essence of which is written concerning the Georgia State Legislature's approval of the new Central State Hospital budget:

"$250,000.00 will be used for planning the renovation of the Boone Building which will be used to house geriatric patients for 1985 occupancy."9

This is a reflection of community concern for the geriatric member's living environment.

This church is a unique one in that it has a built-in system of readily available total care facilities to meet basically every need of the older adult. Every staff member of the church is systematically involved in a process of continuing education consisting of in-service classes, seminars, etc., to provide the highest possible quality of care for the geriatric member.

The high degree of life quality in the Care section of the model contributes, therefore, to a positive response of the geriatric members to the Liberation Ministry of the Institutional Church.

I. Summary

Pastoral care for geriatric persons is certainly the total ministry of the religious community. The writer has sought to develop a model of pastoral care that involves the

entire religious community, bringing to bear its total caring resources upon the older adult. Geriatric pastoral care has been correlated with behavioral sciences to construct a model of pastoral care for the Institutional Geriatric Church.

This model is intended as an example or illustration of what is possible, and each Institutional Geriatric Church must design its own model of pastoral care based upon its own peculiar needs.
CHAPTER VII

CONCLUSIONS AND RECOMMENDATIONS

The intent in this chapter is to restate the purpose of this dissertation, to summarize the methods of the study, to indicate the limitations of the methods and the model of the study, to present a summary and conclusions of the study, and to make recommendations for further investigation.

A. Restatement of the Problem

The problem of this dissertation has been to construct a theory (as represented by the model) of pastoral care that would inform, through implications, the conceptualization of the nature, purpose, and meaning of pastoral care to geriatric persons residing in institutions, more specifically those residing in mental hospitals. The purpose was also to show the relationship of some of the latest theories of aging and their use in the model to the life quality of the above-mentioned geriatric persons. The study has examined the usefulness of theories of aging for their relevancy in developing a model of pastoral care for the Institutional Geriatric Church, especially for those elderly persons coping with change of environment and/or relocation. The underlying question raised for inquiry has been, "How can the Liberation Ministry best serve the needs of the estranged members of the Institutional Geriatric Church?"
Another intention in the dissertation has been to present gerontological data and evaluations which could assist the model-building efforts of the dissertation. A final purpose of the study has been to make recommendations on the basis of the model which are capable of being tested in further research.

B. A Summary of the Study Methods

The dissertation has been organized into seven chapters. Chapters I and II explored religious, social, personal, and educational dimensions of older adult existence. Involved in this exploration was established the validity of the Institutional Geriatric Church as a part of the body of Jesus Christ in the Church of God in the existential world of the estranged geriatric person; the procreation of a Geriatric Theology; a review of gerontological literature detailing the social characteristics of the older American population; societal attitudes (to include religious societies) toward older adults; developmental and personality characteristics and needs of persons during older adulthood; and educational needs, interests, and potentials. Implications for a model of geriatric pastoral care were also raised throughout Chapters I and II.

Chapter III included a brief history of Central State Hospital, an existential overview of the Geriatrics Division of Central State Hospital (the Institutional Geriatric Church), its setting and its concern for the provision of an exceedingly high style of life quality. It further presented raw data of the
population of the Bible Study Group to include their back-
grounds and their reactions and behavior in the Bible Study
classes for later evaluations.

Chapters IV and V offered analyses and evaluations of
the above-mentioned data from theoretical and normative theo-
logical perspectives.

Chapter VI consisted of correlating the analyses and
evaluations from theoretical and normative theological per-
spectives, from which correlation implications were drawn for
the designing process of the model and the actual construction
of the model. It should be added here that through the method
of theological correlation between geriatric pastoral care and
behavioral sciences with the Liberation Ministry concept, the
answer to the underlying theological question—"How can the
Liberation Ministry best serve the needs of the estranged mem-
bers of the Institutional Geriatric Church?"—was discerned.

C. Limitations of the Methods and the Model

The theological method of correlation has been the
primary means by which the model-constructing efforts of the
study have been undertaken. The most obvious limitations of
the study are inherent in this methodology. There is no
theory in social gerontology to meet the demands of the scien-
tific community, and it is further unlikely that we will have
in the foreseeable future such theory that ties together the
complex phenomena in the social and personal systems as they
change through time (see pages 30 and 31 of this dissertation).
Hence, it cannot be claimed absolutely that our study of
theories of aging is absolute. In a succinct manner of communication concerning this matter, the relationships proposed in this study must remain provisional pending further study.

The proposed model of pastoral care for the Institutional Geriatric Church also has limitations in terms of how it will be used within local Institutional Geriatric Churches. Since the research in this dissertation is primarily exploratory and not experimental, the model is limited to the four case studies and cannot be generalized to other Institutional Geriatric Churches. Therefore, the model is intended only as an example or illustration of what is possible, and each Institutional Geriatric Church must design its own model of pastoral care based upon its own peculiar needs. The proposed model is intended to stimulate experimentation by local Institutional Geriatric Churches. Therefore, the model that was developed is not the model of pastoral care for the Institutional Geriatric Church; rather it is only one model that may be employed.

D. Conclusions and Summary

As a result of this study, four sets of conclusions can be made: conclusions about life quality impacted with education, about continuity of life processes in geriatric persons, about Geriatric Theology, and about the community aspect of pastoral care.

It is beyond the scope of this dissertation to present a detailed presentation of material related to the above
mentioned conclusions already presented. However, it is possible to briefly summarize the conclusions as mentioned.

1. Conclusions about Life Quality impacted with Education

Regardless of the degree of life quality, without a continuing process of education, the aged individual will certainly withdraw into seclusion and apathy and preclude the prospect of self-renewal. The writer has known geriatric persons who were in possession of excessive wealth, social position, and political control who disregarded continuing education. They withdrew into seclusion and apathy at a certain period of their lives and developed a state of despair during the remaining period of their lives before death. The evaluation chapters have shown how life quality plus education can aid in the growth of ego strength for the development of integrity in the life of the most destitute geriatric person.

2. Conclusions about Continuity of Life Processes in Geriatric Persons

Chapters II, III, IV, and V have indicated that there are influential characteristics of continuity of life processes existing in geriatric persons religiously, biologically, culturally, traditionally, and theoretically. These influential characteristics, influenced by the life quality of the geriatric person, enhance their positive response to the Liberation Ministry of the Institutional Geriatric Church.

3. Conclusions about Geriatric Theology

The traditional theology, no matter the origin, will no longer serve life purposes when estranged persons become members of the Institutional Geriatric Church. There must be
an awaiting opportunity to celebrate and witness liberation; a nurture of the church to provide the care of sustaining, healing, and guiding; and a hovering umbrella of the Liberation Ministry to shield them from the preclusion of self-renewal and the preclusion of a possible experience of the Liberating Grace of God in the last days of their life on this earth.

4. Conclusions about the Community Aspect of Pastoral Care

The writer concludes that the community, in the context of this study, is a special priesthood ordained by God to help carry out His purposes in His concern for geriatric persons.

It may be succinctly summarized then that the proposed model of pastoral care will, in most instances, serve the needs of geriatric persons and aid in their positive response to the Liberation Ministry in the Institutional Geriatric Church.

E. Recommendations for Further Investigation

This study has implications for further exploration. There are three areas of recommended research including evaluation, descriptive and experimental investigations. The recommendations are the following.

1. Evaluation

It is recommended here that a pilot project be undertaken and evaluated in which the model is operationalized and implemented with four geriatric persons in a local Institutional Geriatric Church in another community. The overall purpose of this evaluation research would be to ascertain how the model
design developed as a part of the project accomplishes the goal of the Liberation Ministry.

2. Description

As a part of the above-mentioned pilot project, it is recommended that the various dimensions of the model as executed in the Liberation Ministry be examined, descriptively, in order to ascertain how these dimensions influence the specific aspects of the geriatric person's response to the Liberation Ministry.

3. Experimental

It is recommended that an empirical investigation be undertaken employing the methods of the conditioned response, perceptions of self and world, the development of personality and existential engagement, these methods to be applied either singularly, plurally, or totally toward the ascertainment of the degree of relative implications of behavioral science and Geriatric Pastoral Care when a "Behavioral Science Group of Elderly Persons Coping with Change" is operationally implemented.

F. Summary

In this chapter, the development of the dissertation has been summarized, the limitations of the methods and the model of this study have been reported, conclusions based on the study have been made, and recommendations for further investigation have been delineated.
BIBLIOGRAPHY


