



# Agenda

**PRESBYTERIAN OLDER ADULT MINISTRY  
CONGREGATIONAL MINISTRIES DIVISION  
PRESBYTERIAN CHURCH (U.S.A.)**

Number 95

April 2001

## **Special Issue on Depression in the Later Years**

### **Depression and Suicide Among Older Adults: The Need For a Faith-Based Response**

*Andrew J. Weaver, M. Th., Ph.D.*

United Methodist minister and clinical psychologist  
Co-Director of Research  
The Healthcare Chaplaincy  
New York, New York

*Harold G. Koenig, M.D., M.H.Sc.*

Associate Professor of Psychiatry and Internal Medicine  
Director, Center for the Study of Religion/Spirituality  
and Health  
Duke University Medical Center  
Durham, North Carolina

**D**epression is the most common and treatable mental health problem among older adults. According to Marty Seligman (1990), former president of the American Psychological Association, depression has increased ten-fold in the United States since the Second World War. Approximately 15 percent of elderly Americans experience a major depression and the rate is almost 25 percent in nursing homes (National Institutes of Health, 1991). It is a far from benign condition, since 15 percent of those who go untreated for major depression commit suicide.

Experts estimate that 10 to 30 percent of seniors have emotional problems (often depression) that are readily reversible when recognized and treated promptly. Many older adults, however, never receive professional mental health care, often resulting in the deterioration of their condition (Waxman, Carner, & Klein, 1984). This has resulted in a suicide rate among Americans aged 65 and over that is 50% higher than the rest of the population, and it is rising rapidly, particularly among older males (Osgood, 1991). Suicide and depression in seniors are issues that clearly warrant the attention of religious communities—one expert argues that 50 percent of

suicides are preventable if helpers, such as clergy, are properly trained (McIntosh, 1988).

Faith communities are central to the lives of most older Americans. More than 75 % of the elderly say that

### **In This Issue**

Depression and Suicide Among Older Adults <i>Andrew J. Weaver and Harold G. Koenig</i> .....	1
From the Editor <i>Richard Morgan</i> .....	3
Depression: A Normal Health Problem <i>Julie A. Dickison and Edward T. Plyler</i> .....	3
POAMN President's Page <i>Kathy Westmoreland</i> .....	4
Musings by <i>Miriam Dunson</i> .....	5
Depression: A Manifestation of Brokenness <i>Douglas J. Freeman</i> .....	5
Depression From a Pastor's Point of View <i>Spencer Murray</i> .....	6
The Elderly and the Prisoners <i>Wesley F. Stevens</i> .....	7
Autumn Wisdom .....	9
Older Adult of the Year .....	10
Resources .....	11
2001 POAMN Conference .....	12

religion is “very important” in their lives and over half worship at a church or synagogue at least once a week (Gallup & Lindsay, 1999). The mental health needs of seniors are increasingly becoming the central counseling concern for clergy. About 50% of the members of mainline Protestant Churches and American Judaism are 60 years of age or over (Koenig, & Weaver, 1997).

A National Institute of Mental Health study found that a person aged 65 or over with a mental health problem (including major depression) is more likely to seek clergy help than assistance from a mental health specialist (Hohmann & Larson, 1993). A Gallup survey found that older adults are more willing to turn to a pastor than their medical doctor or a mental health specialist for help when a friend is contemplating suicide (Gallup, 1992).

Major depressions are usually associated with a predominantly sad mood, hopeless feelings, pessimistic thinking, loss of the ability to experience pleasure, sleep disturbances, agitation, irritability, or restlessness, suicidal thoughts and attempts, and loss of self-worth or feeling like a burden (Weaver, 1993). There is increasing evidence that both depression and suicide may have a biological component—an imbalance in brain chemicals that affect mood. Decreased levels of the chemical serotonin have been found repeatedly in the fluid that surrounds the brain and spinal cord of those who have attempted or committed suicide (Fawcett & Busch, 1993).

Treatment for depression is one of the genuine success stories in mental health. Almost all suffering individuals find improvement from one or more of these approaches: psychotherapy, antidepressant medication, or electroshock therapy (ECT). Mild depression responds to supportive, insight-oriented forms of psychotherapy and, in some cases, ECT.

Many depressed persons describe their life with statements like “everything is hopeless,” “nothing is working in my life,” or “I can’t ever get anything right.” Depressed individuals tend to conclude the worst about themselves, their life situation, and their future. If these beliefs go unrecognized and unchallenged, such distortions in thinking will continue to intensify the emotional pain of depression. It is important to encourage activities that give pleasure and fulfillment to a person, such as religious involvement, that may decrease the emotional pain of depression (Preston, 1997).

Antidepressant medications are effective in the treatment of depression in 70 to 80 % of cases

(Reynolds *et al.*, 1992). They restore the levels of brain chemicals that are depleted when an individual is depressed (Preston, 1997). These drugs are not addictive, and they are neither tranquilizers nor “uppers.” Unfortunately, the effects of antidepressants are not immediate, and some people stop taking them before normal brain cell functioning is restored. In most cases an individual will experience improvement within two or three weeks, but it can take from four to six weeks or even up to eight weeks to be fully effective. The type of medication that works best depends on the side effects and type of symptoms for each individual. Sometimes several drugs will be tried before an effective one is found, but they must be tried at an adequate dose for a sufficient time.

Among some severely depressed persons, when medication has not worked, the only remaining treatment is ECT. It has proven to be particularly effective for those suicidal and psychotic depressed older adults who do not respond to any other form of therapy. ECT is administered as a controlled electrical current passed through electrodes attached to the head, creating a seizure that lasts about one minute. ECT is used only under medical supervision, after an anesthetic and muscle relaxants have been administered (Koenig & Weaver, 1997).

Spiritual well-being is an important factor in predicting depression among older adults. Studies conducted with hospitalized patients undergoing the acute stress of new or worsening physical illness have found that there is a significant relationship between the use of religion as a coping behavior and lower levels of depression (Koenig *et al.*, 1992). Having a deep religious faith can also help persons recover more quickly from depression, as numerous research studies are now showing (Koenig *et al.*, 1998). There are many things that pastors and religious communities can do to help both prevent depression and ensure that people receive adequate treatment when it occurs (see Koenig & Weaver, 1997).

Remember that having depression is not the same as being mentally ill. Many people experience difficulties coping with feelings of depression and anxiety, and there’s nothing to be ashamed of if you have such feelings. The important thing is to obtain help to get over these problems, rather than to remain unhappy and unfulfilled with life. The abundant life is an inheritance for all Christians, and if life is any less than that, then we should make every effort to correct the problems that stand in the way of it becoming so.

.....  
**10 to 30 %  
of seniors  
have  
emotional  
problems—  
often  
depression—**



## From the Editor

**M**iriam Dunson and I have both received repeated requests to address an ever-growing older adult issue in *AGenda: Depression*. So often this is undiagnosed and untreated, and often kept in the geriatric closet. A quick literature search revealed very little available on depression in the later years. The most helpful book on my shelf is Nathan Billig's *To Be Old and Sad*, now out of print.

I am deeply indebted to the writers of this issue who address the issue from a wide spectrum of experience. Harold Koenig and Andrew Weaver are well known for

their book, *Counseling Troubled Older Adults*. Physician Edward Plyler and psychologist Julie Dickison write out of their own work with depressed older adults. Psychologist Doug Freeman brings a theological focus on depression in older persons, and Spencer Murray wrote from his work as a pastor. I trust you will find this edition helpful, either as an older person struggling with this disease, or a professional who must deal with God's oldest, and sometimes saddest, friends. I believe this confirms that *AGenda* is a publication that stays on the cutting edge of aging in the 21st century.

Richard L. Morgan

---

## Depression—A Normal Health Problem

*Julie A. Dickison, Psy.D.*

A clinical (primary care) psychologist., a former program director for research and clinical treatment in both industry and the public sector, in private practice in Morganton, N.C.

*Edward T. Plyler, M.D.*

A board-certified family physician and a Fellow of the American Academy of Family Physicians, in private practice in Morganton, N.C.

**B**etty has been having problems getting to sleep or wakes up 'way too early. She hasn't been interested in bridge club, knitting, or gardening for a couple of months. It's been hard just to get the energy to straighten the house. Nothing seems to matter anymore. She misses her children and grandchildren, but has not told them how she's feeling because she doesn't want to bother or worry them. She's not hungry and doesn't feel like cooking. She's forgetting little things, like where her car keys are or the paragraph she just read in the newspaper, and she's worried that she's getting Alzheimer's or something. And she's starting to feel guilty about the little things that previously did not make any difference.

Betty lost her husband three years ago. She misses him every day, but feels that she has done a good job dealing with his loss and the huge changes she had to make. All the things he used to take care of and all the little kindnesses he extended every day—these things Betty remembers, but now does for herself. She had worked hard all her life and considers herself a strong person who grew up in a strong and independent family, handing down that strength to her own children (who are now settled in other states). She takes medicine for her arthritis and diabetes, but she doesn't believe any medicine is going to help this—it's normal to feel this way when you're older.

Betty isn't alone, but these feelings are actually signs of major depression, which is a very treatable condition. Did you know that in any given year about 2 million adults age 65 and older have a depressive illness? About 80 percent of the people with depression can almost always improve if they get some medication, psychotherapy, or a combination of the two. But only 38 percent of older adults believe that depression is a "health" problem, and they're more likely to want to "handle it themselves."

Depression is a hard thing to handle alone. It can result from losses like a death or changes in independence, economic stress, chronic illness or even from taking certain medications. Some worrisome memory problems can actually be symptoms of major depression, and these memory and concentration problems may clear up if the depression is treated. It's very important to discuss memory problems, feelings of sadness, or changes in sleep or appetite with your physician, because they can have several causes. Even though depression is a major cause and can be reversed, other medical causes need to be eliminated. It is *very important* to discuss symptoms and/or concerns with a doctor.

Depression can also go along with medical conditions and even be a side effect of medications. An underactive thyroid can cause marked depression, as well as

constipation, hair loss, a slow heart rate, or weight gain. Patients with diabetes are three times more likely to have major depression. Forty to 65 percent of heart attack survivors have depression, and 20 to 25 percent of cancer patients are thought to suffer from major depression at some point during their illness. Many of the drugs used to treat cancer can cause depression as a side effect, as can blood pressure medicines or steroids like prednisone. Drugs like phenobarbital, beta blockers like Inderal, Valium-like nerve medicines, and of course alcohol have also been linked to depression.

If you have some depressive symptoms, even a few, it might be useful to sit down with your physician and review your medications and the stresses in your life. Although an antidepressant medicine would be “one more drug” added on, its effectiveness might result in your not needing other medicines (a sleep medicine or nerve medicine or vitamins due to a poor appetite). Your doctor can supervise the usefulness of such a medicine and determine whether others will no longer be needed.

Psychotherapy can be a powerful tool when used

alone or with medicine—the basic assumption is that the medicine helps people get more sleep or energy, but it cannot take care of the basic issues like grief, independence, stress, or whatever drives the depression. Therapy can help people work through their feelings. A therapist has a longer appointment time that allows for more personal expression and interaction, which a physician’s appointment schedule isn’t in a position to offer. A psychotherapist is also trained to help identify and pull together meaning from people’s lives and help them succeed. A psychotherapist can be a clinical psychologist, a psychiatrist, a social worker or a nurse practitioner. Any psychotherapist should be licensed in the state where they practice—just ask. Your doctor can make a referral to a therapist, if needed. It’s not “normal” to feel depressed when we’re older, and with education and treatment maybe fewer people will have to.

If you would like some more information on depression in the later years, contact the National Institutes of Mental Health at (301) 443-4513 or visit them on the Web at <http://www.nimh.nih.gov>.

---

## POAMN P RESIDENT 'S PAGE

*by Kathy Westmoreland*

**A**s you have read elsewhere in this issue, depression could be considered an epidemic among older adults. The church stands in a unique position to be an advocate for older adults in this area. A little creativity can make a big difference! Here are a few suggestions:

- Fight the stigma associated with mental health by having regular articles in the church newsletter about depression. This can be effectively done at the holidays, or in June when many wedding anniversaries are celebrated, or when the congregation has suffered a number of losses. You can also encourage your pastor to mention issues related to depression from the pulpit or have adult forum speakers on the subject.

- Make sure your pastor has a good referral list of mental health professionals who specialize in older adults. There are those who think that it is natural for older adults to be depressed.

- Educate deacons and others who visit older adults about the signs and symptoms of depression so that they can alert the pastor. Depression is treatable and no one should have to live in a depressed state.



- When an older adult begins to withdraw from congregational life, do not accept that as normal. Do all you can to keep them involved in the life of the church. That may mean changing meeting times or places, finding new volunteer ministries within the church, creating the role of “committee consultant” for folks who have been active in a particular area for a long time so that they know their expertise and wisdom is valued.

- Be attuned to losses and how older adults are grieving those losses. Depression often develops after a series of losses that have not been fully grieved.

- Utilize community resources to become better educated as a congregation.

The church should always be the bearer of hope for people who are hurting. For we have the greatest healing of all to offer the love of God in Jesus Christ!

Peace,

Kathy Westmoreland

## MUSINGS BY MIRIAM

# But What About Me? I Get Depressed Too!

by Miriam Dunson

**M**uch is written about the depression of the older person who is experiencing many losses, with suggestions as to how to deal with that kind of depression. Many churches build relevant responses to these losses by building support groups for the transitions, doing a series of special studies or lectures on transitions; staying in touch with older persons and helping them to feel special, valuable, and important in spite of all the changes in their lives.

However, not much is written about, nor does the church do much to identify or address, the depression of the rest of the family who stand by watching the deterioration of the health of the parent. No matter how much or how little we do for our ailing parents, we will be filled with guilt. The depression comes from the loss of the parent as he/she was, the role reversal of the adult child caring for the parent, watching the deterioration of the parent in later years, anticipating the death of the one who has given you life. Not to be left out as well is depression brought on by the extreme cost for the care of the parent in later life, with the responsibility for paying the bills falling to the adult child, in many

situations. Medicare and Medicaid are helpful as far as they go, but they do not cover everything needed, nor adequately cover those needs that are covered. The church can: (1) Hire a parish nurse to stay in touch with and monitor the health of the adult, as well as the caregiving, and family situations. (2) Develop support groups for the family members as well as caregivers who may or may not be family members. (3) Maintain close contact with the family through visitations, phone calls, and listening sessions. (4) Develop a care team made up of members of the congregation for that specific situation, who can provide professional and non-professional care for the older adult as well as for the family members, especially in the case of illness from Alzheimer's disease, AIDS, or other long-term or chronic illnesses. (5) Establish a prayer team who pray specifically for the identified need. (6) Develop a support group for long-distance caregivers who may have to leave at a moment's notice at a crisis time, the group to take care of the house, pets, plants, responsibilities, etc., of the family member who had to leave quickly to be at the side of the loved one.

---

## Depression— A Manifestation of Brokenness

by Douglas J. Freeman, Ph.D.

**W**orking as a practicing psychologist for nearly 30 years has provided me with a unique window on the human condition. I have been fortunate to have thousands of individuals of all ages come into my consulting room and tell me their stories. It has never ceased to amaze me how quickly and easily people will divulge their most cherished secrets to a total stranger.

I am sure there are many reasons for this. Many people do not have adequate opportunities for sharing the stories of their life, lacking access to sufficient intimacy. It may be safer for some to share their life with a stranger who is sworn to maintain their privacy. And many people are experiencing deep psychological and emotional pain and are eager to speak to a professional who may be able to help them find their way out of the pain. Whatever the reasons, listening to

these stories has taught me a great deal about what people in our world are experiencing today.

We live in an era in which complaints of depression are at epidemic proportions. Mental health professionals, physicians, pastors, and counselors of all stripes spend a significant portion of their time responding to depressed individuals. The diagnostic manual widely used by mental health professionals has a variety of ways of describing depression, based upon the severity, the length and the frequency of the symptoms. Depression gets described as part of an adjustment disorder, as dysthymic disorder, as major depression, or as a part of bipolar disorder. Depression is talked about as clinical depression or as reactive depression in the media. Estimates of the impact of these disorders on our culture are staggering.

Modern scientific treatment approaches to depression have produced significant advances in the span of the last two decades. Recently introduced medications for the treatment of depression have lifted the burden for many. Psychotherapeutic and counseling approaches, especially those using a cognitive/

behavioral approach, are impacting depressive disorders with a high success rate. Exercise and healthy-living programs make a positive contribution. There are many avenues for a person with depression if they want to reach out and seek help. And the sources of help are likely to be effective. Textbooks about depression describe it as a biopsychosocial disorder. This means that depression is thought to occur from biological, psychological and/or social factors. Any or all of these factors may be a root cause for depression, but typically it is a combination of all of these factors. Scientifically trained medical and psychological practitioners have typically been uncomfortable including spiritual factors within the list of causes or treatments for mental disorders. In recent years, however, a growing number recognize the empirical and/or the intuitive evidence that spiritual factors are important in establishing healthy lives and lifestyles. We are witnessing the “respiritualization” of contemporary life, and this process is affecting medicine and psychology as well as all other aspects of our lives.

From a spiritual perspective, depression is a manifestation of our brokenness. Our lives, as well as the lives of those in the spiritual stories of the Bible, are full of examples of alienation and separation from the love of God and the love of mankind. If we view life itself as a gift from God, then at the beginning of our life we are just freshly arrived from God. We are not yet in a state of brokenness. We are still perfect, or nearly so. But it doesn't take long for this to evaporate. The long trek through life, our spiritual journey, is perhaps a journey back to the center of our existence, back to our source, our Creator. The grand cycles of creation, fall, judgment, and redemption have been completed again and again. Each time through the cycle depression is a reminder of our separation, our helplessness and hopelessness as we are separated from the reassuring arms of human and/or Divine love.

Older folks may have realized their gift of wisdom. They may have learned already that a person cannot easily fight his or her way through depression alone. They may have learned that reaching out to another source of love will make their struggle easier. They may know that the courage to find solutions to difficult problems is given us, not only by loved ones, but also by strangers we have scarcely met on the journey through life.

---

*Douglas J. Freeman, Ph.D., is a licensed psychologist practicing at the Counseling Group, Inc. in Hickory, North Carolina. You may contact him by writing to 106 Third Ave. N.E., Hickory, NC 28601, or by e-mail at [dougjf@charter.net](mailto:dougjf@charter.net).*

## Depression From A Pastor's Point Of View

*by Dr. Spencer Murray*

### Depression and the Elderly

Over a period of 40 or more years, a pastor learns to look over a Sunday morning congregation with different eyes. The congregation appears normal in all respects, appropriately dressed, faces calm and receptive. But these are the masks. And as a pastor knows, there can be a load of troubles behind the masks. On the left about halfway back sits a man who lost his wife of 48 years some six months ago. He goes to her grave two or three times a week to sit and talk to her. In the center toward the rear is an elderly woman who cares for her invalid sister. She comes to church when a helpful neighbor offers to stay with the sister. On the right near the rear sits another woman with an air tank in front of her and tubes leading to her nose. In the aisle is her wheelchair. Her daughter faithfully brings her to church.

What do all of these have in common? Not their troubles, for they are different. It is their depression. Yet, ask any one of them about depression, and they are apt to deny it. “Depression” refers to what the country went through in the 1930s, not what they are feeling and experiencing now. During these days they feel tired most of the time, discouraged, and don't have much to look forward to. The fact they suspect that things will remain the same or get worse leaves them in their circumstances, and you may receive nothing more than a bare smile while the eyes express disbelief.

Depression is one of the most common ailments in the elderly. The experiences of loss are common. Retirement, illness, loss of spouse, moving to a smaller residence, or disability each carries its own loss. And the normal response to loss is grief, most often in the form of hopelessness. The tendency is to withdraw from other people. Someone once told me, “I want to pull the covers up over me until I am invisible.” It is just too hard to work on relating to others.

Through it all God seems to have gone into hiding. The psalmist cried, “My God, why have you forgotten me?” His own tears were his food day and night. Here depression becomes an issue for faith, because the Christian antidote to depression is hope. But hope cannot be given in the form of a pill. It must be created. Creativity, in any of its forms, brings hope and causes it to grow. One reason withdrawal is harmful is that it feeds hopelessness and stifles creativity. Over the years

I have found that if the depressed person can be coaxed into returning to a hobby, then hope comes back. Gardening, painting, making music, serving as a volunteer, whittling, or any other such activity brings hope. Depression flees in the presence of hope.

Christian hope is different from wishful thinking. One of the realities about aging is that things may not get better and may in fact get worse. The losses mount up, and one's health may continue to decline. Hope

does not depend on things getting better. Hope expects what faith believes God has promised. And God has promised to walk with us through the valley. The aged have one advantage—they have more past experience than the young. They have years of evidence that God has been with them. Hope always utilizes this past and builds on it. It is hope that gives value, meaning, and personhood. This is the ultimate creativity.

---

## The Elderly and the Prisoners: A Special Kinship

*by Wesley F. Stevens*

**O**ut of the accumulated experiences of ministering to both older people and prisoners, I am struck by how much these two groups reflect similar characteristics of marginalization. A commonly held opinion of the frail elderly and those who are serving time in prison is that those in both groups fall into the category of useless. The guilty group, the prisoners, receives the most direct and unambiguous rejection. The innocent group, the elderly, are victimized by benign neglect and subtle evasion.

For 27 years as an ordained United Methodist minister I served as Administrator of a Christian Retirement Community in Houston, Texas. I learned how living into deep old age presents a variety of problems, not the least of which is being separated from home and traditional ties of comfort and assurance.

For the past three years, a very short time in comparison, my wife and I have been engaged in a far-reaching ministry to men and women in jails and prisons. We have learned, through many experiences, what the general public thinks about those who are incarcerated. The most generally expressed opinion is that they got what they deserved. We are surprised by how many family members do not visit or even write to a loved one in prison. In spite of a growing number of exceptions, the prevailing attitude is “out of sight, out of mind.”

My wife and I have observed that older people and prisoners, when given the opportunity to think about it, will express concern for each other. We were gratified when an organization of active older people in a local church, after I spoke to them about prison ministry, volunteered to donate Christmas cards for the use of women at the state jail where we serve. Some of the women in the group offered to bake cookies for volunteers to take into the prisons in conjunction with a

special weekend program. One gentleman stood in line to tell me that he would donate some new building material in his possession for our project of getting a Family Visitors' Center built to serve three nearby prison facilities. From the other side, men prisoners at a location I visited several years ago made innocently touching greeting cards for elderly residents of the retirement community I served. They thought of older men and women as those who, undergoing a different sort of hardship, might appreciate a special remembrance. These gestures reflect a concern for others prompted by the recognition of mutual burdens. I lament the widespread failure of the church to care for those who yearn for an acceptance that, in spite of their weakness and failure, will embrace them with the kind of love that risks everything for the sake of the gospel.

In addition to both groups sharing the label of unwanted, there are specific marks of kinship in the treatment and in the living conditions of the elderly and those who are in prison that are worth noting.

While it is true that a small percentage of older people, those who are in nursing homes, can be thought of as being locked in place, other older people are subjected to a kind of isolation akin to the experience of many of those who are incarcerated. In both cases movement is restricted. Certain housing facilities for the elderly have cameras in place to monitor the hallways. Prisons often utilize the same kind of surveillance procedures.

Many elderly people depend on meals-on-wheels and agency assistance for medical service. The poorer elders, late in life, may languish in sub-standard nursing homes or suffer limited medical assistance in whatever desperate circumstances they are able to survive. Elders who have sufficient financial resources to live in facilities built and managed for their age group discover

that such “apartness” deprives them of the kind of life they once enjoyed.

In prisons, where the greatest concern is for security, there is not a lot of emphasis placed on nutrition and health care. Prison doctors are often at the bottom of their profession and nursing personnel have limited supplies and the lack of incentive to do a good job in treating those who many of them perceive as undeserving.

The basic needs of nursing homes and prisons often suffer from budget constraints. Limited resources result, to a large extent, from the commonly held opinion that the elderly do not count for much and that those in prison deserve only punishment. In a market-driven culture neither group has strong advocates in state legislative assemblies.

In the regimented living conditions of nursing homes and prisons, those who are in authority are often viewed by patients and prisoners alike with distrust. However, some long-tenured employees relate well to both groups. Employees who are new on the job at prison facilities are frequently blamed by the inmates for causing more lock-downs, more cases being written against them, and fewer privileges being allowed. Nursing home residents may have a hard time accepting a new aide or attendant, blaming them for a different bath schedule, less desirable snacks, or rougher handling. New employees in both settings may open themselves to criticism and correction by peer employees if they apply themselves with exceptional diligence to their work. Unfortunately, good people can be intimidated by “old hands” into accepting a minimal performance level. Such coercive influence sometimes causes weaker employees to become indifferent and contemptuous of those for whom they have a custodial responsibility.

Prisoners, like the frail elderly, have practically everything decided for them: what and when they will eat, what they will wear and when they can go outdoors. Such enforced dependency creates serious personal problems. The confinement of elders may erroneously be thought of as more natural to their time of life. Prison, on the other hand, leaves little doubt as to how much it severely limits the lives of those who grow old inside the razor wire of prison confinement.

The tragedy of many of those who live in nursing homes and prisons is the loss of identity. Nobody knows or cares much about them. The infirm elderly are called by names such as “honey” or “dear.” The prisoners are

identified by numbers and are called by names that serve only to weave them more tightly into the tattered fabric of prison life. Their true selves, in many instances, have been hidden for so long they have withered away. However, those who may have never lived well, or who may have never understood the limits of life, need to have a chance to receive the healing ministry of the church, to allow the stories they hear of Jesus to become their stories.

As the days of the nursing home elderly slip away, some are able to lift weary but thankful eyes to those who spend more than a few, hurried moments with them. A caring hand placed upon them as death draws near enables them to experience a blessing important to their departure from this earth. Sadly, invasive medical procedures often prevent such human contact. Sometimes a depressed or terminally ill older person, who has no one who really cares for her/him, will consider suicide.

In prison those who have been condemned to death by the criminal justice system experience, near the end of their lives, certain procedural “last things.” As they are strapped to the gurney in the execution chamber, just before lethal fluids enter their bodies, they may feel the touch of a chaplain’s hand. Others in prison die or take their own lives without anyone near to offer words of comfort. To those who, in caring faith, make contact with those who are dying, Jesus says, “Inasmuch as you have done it unto the least of these, you have done it unto me.”

The frail elderly have a kinship with the prisoners in the lesson they both can teach the rest of us. They exist for us in ways that enable us, in Jesus’ name, to embody acceptance and forgiveness. Regardless of how they are perceived by a callous public, we are called to engage them in the kind of faith dynamic that offers no excuse for their wounds. We are privileged simply to enter their lives as emissaries of the Christ by whose own wounds healing is possible.

Because of the severe dislocation of the elderly and those who are in prison, we are directed to provide a tabernacle of God in their midst. Abiding with them, in whatever ways we are capable, as human agents of God’s redemptive love, we testify to the promise of a food that nourishes, a shelter that is safe, and a resurrection hope that never dies. These witnesses to trouble in the land are the ones who will determine whether or not we can be counted among God’s faithful people.

.....  
***A commonly held opinion of the frail elderly and those serving time in prison is that they are useless***

## Autumn Wisdom



At age 65 the average person has a life expectancy of another 15 or 20 years. . . .

These years can be enjoyable, productive, and fulfilling years.

Depression can make them a series of nightmares. . . . Depression, if treated, is not life-threatening. Once depression is stabilized, an older person can look forward to an otherwise normal life. "Getting old" cannot be treated, the disorder of depression can. It is worth making the effort.

—*Nathan Billig, To Be Old and Sad*

Some of the Bible's most notable characters experienced depression. David, Elijah, Jonah, Job, Jesus. Yes, Jesus. On the advent of His arrest and soon crucifixion, Jesus said to His disciples, "My soul is exceedingly sorrowful, even unto death." Anyone who has ever been depressed knows there is no better definition of depression than this.

—*French O'Shields, Slaying the Giant*

### Depressed again?

I battled depression 10 years ago when I first retired. I felt discarded like an old piece of furniture. The stimulation and affirmations of my work were gone, and all that was left was a big void. So, I "flunked" retirement and became as busy as when I was working. Now, 10 years later, the years have taken their toll. I have to slow down, relinquish cherished work and the role I played, and live a quieter lifestyle, painfully aware that time in my shrinking world is running out.

I battled depression once more—but this time found that the answer is not in busyness or activity, but in quietness and "the still, small voice." Believe me.

—*Richard L. Morgan*

### Phil-osophy Security blankets

As we get along in years, there is a tendency to become obsessed with security.

We limit our associations to longtime friends, we go only to familiar places, we play the same records over and over, and we converse only with those who will reinforce our deeply felt beliefs. But there is the potential for growth throughout our entire lifetime.

There is always

- a need for new ideas to stimulate thinking a new song waiting to be sung

- a stranger to befriend
- someone in pain who needs comforting
- new stars that appear in the heavens to remind us that Creation and creativity are never-ending processes.

—*Phil Skarin*

### The Day Winter Came

The day winter came  
I was not prepared.  
A sign of age upon me  
could be read.  
But, runners flashing by  
hardly noticed  
My time-worn frame.

In blissful days of spring  
when I ran,  
My supple body sang,  
"forever young."  
Now, walking the track,  
expansiveness  
Is only in my head.

Summer lingered happily  
until, at length,  
The leaves of fall,  
banked like snow  
Against the leaning fence  
that framed the yard,  
Free, but grounded.

The day winter came,  
warning bells rang;  
A frigid zone was felt  
against my heart  
Resisting an invasion of despair,  
I gave myself away.

—*Wesley F. Stevens*

"The trauma of depression is devastating. Friends tell you to look up and see the sun and the trees. They don't know that for you there is no sun, there are no trees. The depressed person is, like Dante's Prince of Darkness, encased in ice, in hell.

When the reaction to the blows of life is depression, it is difficult to melt the ice and go on with life. But it can be done, and once you are in the light again, life takes on a beauty you couldn't have imagined before.

—*Antoinette Bosco, The Pummled Heart:  
Finding Peace Through Pain*

## Excitement Is Rising!!!

**E**xcitement is rising in the Office on Older Adult Ministry! We have launched an ambitious funds development program that has a reachable goal of \$6 million within five years for an endowment fund with the Presbyterian Foundation. This Endowment Fund will ensure that the Office on Older Adult Ministry will never again face the threat of closure, nor face the threat of diminishing budgets. With the interest on the endowment we will not only be able to expand the older adult ministry leader development events in

congregations, presbyteries and synods, but will also be able to provide the best tools and resources for the best trained leaders on all levels of the Presbyterian Church (U.S.A.).

Think about the needs not being met among older adults. Think about the challenges faced by older adults. Think about the many skills and talents older adults bring to the church if only given the opportunity. Think about how you might become a part of this exciting venture.

For further information, telephone Dr. Miriam Dunson, 1-888-728-7228.

### Older Adult of the Year Nonagenarian John Meares

*AGenda* honors John Meares of Cary, North Carolina, as its Older Adult of the Year. John reached his 90th birthday recently and celebrated by preaching at the First Methodist Church in Cary on “Two Lives to Live.” He said, “People say, ‘You have only one life to live, live it up.’ But we have two lives to live—one here and one in eternity—and the greatest use of life here is to spend it for something that will live after it.”

John Meares has led such a life. Born in 1911 in Columbus County, North Carolina, he served in the Navy aboard ship as a radio operator, and taught pilots how to read Morse code during World War II.

John Meares’ greatest contribution has been to the United Methodist Church. Much of his devotion to the church has filtered into 17 states over 60 years of dedicated service to Jesus Christ. He has also been a leader in older adult ministry, working for AARP, and teaching courses on “Reminiscence and the Healing Power of Humor.”

John broke a hip a year ago when he fell off a ladder pruning a tree (at age 89!). Undaunted by this accident, he’s using a cane he made himself.

John closed his sermon on his 90th birthday by telling the congregation: “Life is like a game of tennis. You can’t win without serving. Our task is to feed the hungry, welcome the stranger, care for the sick. To make old age a success, serve when young. I hope that I will live so that when I die I will be happy and you will be happy that I have lived.”

No doubt this wonderful nonagenarian with his pointy little white beard and twinkling eyes has made many people happy with his contagious humor and love of life. *AGenda* honors John Meares as it Older Adult of the Year.

If you would like to send John a card or letter, write him at: John Meares, 1006 Ponds St., Cary, NC 27511.

#### NOTE:

If you wish to receive *AGenda* regularly or have a change of address, please e-mail miriamd@ctr.pcusa.org Or you can telephone 1-888-728-7228 and ask that your name be added to the list or address changed.

#### **AGENDA EDITORIAL BOARD**

Publisher	<b>Miriam Dunson</b>
Editor	<b>Richard L. Morgan</b>
Associate Editor	<b>Ed Loper</b>
Associate Editor for Resources	<b>Aaron Fulp-Eickstaedt</b>
Copy Editor	<b>Lottie Swink</b>
Copy Editor	<b>Alice Ann Morgan</b>

## Resources

- Billig, Nathan, *To Be Old and Sad. Understanding Depression in the Elderly*. Lexington Books, 1987 (Out of print).
- Binford, W. Gilbert, *The Pastoral Care of Depression. A guide book*. Haworth Press, 1998.
- Burns, David, *The New Mood Therapy*. Penguin 1980.
- Greenberg, Vivian, *Respecting Your Limits When Caring for Aging Parents*. (See chapter 15.) Jossey Bass, 1989.
- Koenig, H. G., and Weaver A. J. *Counseling Troubled Older Adults. A Handbook for Clergy and Other Religious Caregivers*. (See pp. 41–54.) Cokesbury Press, 1997.
- Koenig, H. G., *Pastoral Care of Older Adults*. Fortress Press, 1998.
- Koenig, H. G. *The Healing Power of Faith*. Simon and Schuster, 1999. Available in paperback 2001.
- Martyn-Lloyd Jones, David. *Spiritual Depression*. Zondervan, 1989.
- Mosher-Ashley, Pearl, *et al.*, *A Life Worth Living: Practical Strategies for Reducing Depression in Older Adults*. 1997.
- O’Shields, French, *Slaying the Giant: Practical Help for Understanding, Preventing, and Overcoming Depression*. Hem of His Garment Press, 1994
- Preston, J. D., *You Can Beat Depression*. Impact Publishers, 1997.
- Preston, J. D. and Johnson, J. *Clinical Psychopharmacology Ridiculously Simple*. Impact 2000.

---

### A Must Reading on Depression

In his beautiful little book, *Let Your Life Speak* (Jossey Bass 2000) (\$18.00) Parker J. Palmer devotes the 4th chapter to his experience with depression. Entitled “All the Way Down” Palmer tells the story of his “sojourn in the dark,” and how he saw depression “not as the hand of an enemy trying to crush you, but the hand of a friend, pressing you down to ground on which it is safe to stand!” *Working with older persons you will find this chapter an invaluable help in understanding the meaning and the journey back to wholeness.*

—Editor

---

### Online Resources

Depression Awareness, Recognition, Treatment (DART); sponsored by the National Institute of Mental Health, 5600 Fishers Lane, Rockville, MD, 20857; (800) 421-4211; [www.nimh.nih.gov/newdart](http://www.nimh.nih.gov/newdart). Provides free information and literature on depressive disorders, symptoms, treatment, and sources of help. Publications available in Spanish, Asian languages, and Russian.

National Depressive and Manic-Depressive Association; 730 North Franklin Street, Suite 501, Chicago, IL 60610; (800) 826-3632; [www.ndmda.org](http://www.ndmda.org).

National Foundation for Depressive Illness, Inc., P. O. Box 2257, New York, NY 10116; (800) 239-1265; [www.depression.org](http://www.depression.org). A 24-hour recorded message describes symptoms of depression and manic depression and gives

addresses for more information, physician and support group referrals by state.

Stephen Ministries; 8016 Dalke Avenue, St. Louis, MO 63117; (314)645-5511. Offers training in counseling skills for local church members. Five thousand congregations worldwide offer this ministry.

---

### Two Great Web Sites For Older Adult Ministry

Henry C. Simmons at the Center on Aging of Union-PSCE has compiled a great Web site with printed resources on religion, aging, and spirituality—more than 1,500 books, articles, and dissertations on such subjects as: Church and Synagogue, Ethics, Personal Spiritual Life, Life Review, Death and Dying, and Theology. Just log on to <http://learn.union-psce.edu/aging> or through the home page ([www.union-psce.edu](http://www.union-psce.edu)).

# “Congregational Care for an Aging Population”

2001 POAMN Conference

*October 24–27*

Scarritt-Bennett Center  
Nashville, Tennessee

**Keynote Speaker:** Thelma C. Adair, Ed.D.

**Worship Leader:** Rev. Warner Durnell

Workshops from introductory to more advanced topics, ranging from Adult Day Care to Family Care Giving, Congregational-Based Senior Programs, Ministry with Newly Retired—and more!

There will be opportunities to meet others engaged in a variety of older adult ministries across the church.

Partial scholarships are available for first-time participants. For conference brochure, contact Dana Shackelford at 1-888-728-7288, ext. 5471, or Miriam Dunson at 1-888-728-7288, ext. 5487

*Agenda* is published quarterly and circulated free of charge (single copies only) to persons interested in ministry with older adults. Churches are encouraged to make photocopies of this publication for all older adults in their congregation. A ministry of the General Assembly Council, Presbyterian Church (U.S.A.).

Presbyterian Church (U.S.A.)  
Room 1615  
100 Witherspoon Street  
Louisville, KY 40202-1396

Non-Profit Org.  
U.S. Postage  
PAID  
Louisville, KY  
Permit No. 1215

AGENDA