Parent Care and Religion: A Faith-Based Intervention Model for Caregiving Readiness of Congregational Members

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Despite religious edicts and demographic realities that accentuate the need for faith based eldercare programs, communities of faith have not responded adequately to the needs of older persons and their families. Theoretical frameworks in successful aging that incorporate spirituality and evidence based models of intervention designed for congregations have not been available. The authors provide a theoretical framework for successful aging that incorporates spirituality as an underlying principle, describe an evidence-based approach for faith based interventions with older persons and their families, and highlight a state of science model of parent care. Application of this model in keeping with the successful aging theory and intervention framework provided will unify communities of faith, and generate needed, efficacious programs that prepare adult children and their parents for late life.

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> When Jesus saw his mother, and the disciple whom he loved standing near, he said to his mother; "Woman, behold, your son!" Then he said to the disciple, "Behold, your mother!" And from that hour the disciple took her to his own house. (John 19:26-27)

Irrespective of one's religious convictions, Jesus' strategy for the care of his mother at the time of his death encourages all of us to examine our own personal parent care plan. For reasons not fully understood, Jesus entrusted the care of his mother to John, one of his disciples, and perhaps his closest friend and a member of his religious family. Though we are not privy to the factors behind Jesus' decision, we know that admonitions to *honor thy father and mother* are found in the orthodox teachings of most world religions (e.g., Islam, The Readings of Muhammad, *The Qur'an*: 17: 23-24, Judaism, one of the Ten Commandments, *Exodus:* 20:12). Based on a Christian model of family life, Jesus affirmed the importance of caring for parents by his own example on the cross and through his teachings on the subject (*Matthew* 15:3-9; *Mark* 7:9-13). The Apostle Paul restated the Fifth Commandment (*Deuteronomy* 5:16), and emphasized the importance of parental caregiving and the benefits that accrue to those who fulfill parental responsibilities

(*Ephesians* 6:1-3; 1 *Timothy* 5:1-4).

Despite the consistency of these instructions and those found in other religions, most churches, synagogues, mosques, and other communities of faith in the United States do not provide practical parent care guidance to adult children and their older family members (Holstege & Riekse, 2002; Parker, 2003). In part, this is a reflection of the general paucity of applied gerontological research and training with faith-based communities in the area of parent care. For these and other reasons, conscientious professional and lay religious leaders have increasingly found themselves largely unprepared to address the growing needs of older persons in their faith communities and their families (Parker, 2003).

Communities of faith are, however, in excellent positions to help American families plan for the care of their older members. Americans are strong believers in God and attend religious services regularly (Koenig & Brooks, 2002; Brooks & Koenig, 2002). They are more likely to rely on their own faith and on advice from their clergy in addressing family problems than they are to rely on social service or other community agencies. This trust in faith and clergy is particularly true for underserved groups (Jackson & Reddick, 1999; Jackson & Parks, 1997). Further, research evidence also demonstrates the strong positive association between faith, religious attendance, and good health, particularly in the later years (Koenig, 1999; Larimore, 2002).

In this paper we address faith-based, parent care readiness and training in four ways. First, we provide a brief synopsis of relevant literature regarding parent care. Next, we link an empirically based theoretical model of successful aging that incorporates spirituality (Crowther, Parker, Koenig, Larimore, & Achenbaum, 2002) to parent care assessment and planning. Leaders in communities of faith can use this conceptual model to help develop comprehensive parent care training programs for their own congregations. Third, we present an empirically tested, community-based framework that uses a faith-sensitive, ecumenical approach for parent care training that is aimed at improving the well-being of older persons (Parker, Bellis, Harper, Bishop, Moore, Thompson, et al., 2002). Finally, we adapt for faith-based communities an evidence-based, parent care intervention program that has been informed by previous research sponsored by the Hartford Foundation and the Gerontological Society of America at the U.S. Air War College (Parker & Martin, 2003). Our overall goal is to provide religious leaders (and human service providers interested in faith-based work) an effective approach to preparing families for the developmental task and religious duty of "honoring mother and father."

An Overview of Parent Care in the U.S.

Increases in life expectancy, growth in female labor-force participation, decreases in fertility rates, expansion of family mobility and geographic separation, and development of more diverse, multigenerational family structures affect the capacity of families, including those in communities of faith, to care for older family members (Dilworth-Anderson, Williams, & Cooper, 1999; Baldock, 2000). Reviews of related research on family caregiving suggest that both proximate and long distance care providers are not prepared for the normative developmental task of caring for older family members (Parker & Martin, 2003; Parker, Call, Dunkle, & Vaitkus, 2002). Instead, many individuals at midlife find themselves reacting to health care crises of their elderly family members. Caregiving roles have increased in importance as the population has aged (Pandya & Coleman, 2000; Toseland, Smith, & McCallion, 2001), and as older persons who live at home and in other community settings require assistance because of functional limitations associated with chronic disease and disability (Parker, Baker, & Allman, 2002). These demographic imperatives are having a dramatic impact on family, organizational and congregational life in the U.S.

Employers and service organizations are increasingly aware of the potentially adverse impact of parent care on productivity (National Alliance for Caregiving, 1997; Neal, Chapman, Ingersoll-Dayton, & Emler, 1993). The national economic value of informal family caregiving has been estimated at almost $200 billion per year, approximately 18% of the total national health care spending in the US (Arno, Levine, & Memmott, 1999). Although the costs of caregiving to religious organizations have not been studied (e.g., inability of members to donate time and money because of caregiver responsibilities), parent care is costly to employers and employees. One national study has estimated the costs of replacing employees, absenteeism, workday interruptions, eldercare crises, and supervisors' time at $1,142 per employee, and the annual, aggregate cost to U.S. business of decreased productivity of employees with caregiving responsibilities at $11.2 billion (Metropolitan Life Insurance Company, 1998).

Although numerous books, journal articles, and Internet sites are available to assist those faced with filial responsibilities, the effects and potential benefits of these informational sources have not been thoroughly investigated (Parker, Roff, Toseland, & Klemmack, 2003). Many families faced with a parent care crisis, whether on a day-to-day basis or from a distance, do not use this information. Others who access this information do not find it user friendly because it is often provided in

a smorgasbord fashion that can be complex and confusing (Parker, 2003). The caregiver often must wade through extensive, nonessential information in search of answers to his/her specific questions without the benefit of expert guidance and support.

A growing number of caregiving intervention studies have been conducted. Reviews of the literature indicate that participation in individual and group intervention programs with caregivers and the use of day care and other community resources for care recipients can be effective in supporting family caregivers' efforts to maintain cognitively and physically impaired older persons in community settings (Schulz, 2000; Zarit, Gaugler, & Jarrott, 1999). In fact, there are now studies that indicate that caregiver support programs can delay nursing home placement and reduce health care costs for care recipients (see, for example, Brodaty & Peters, 1991; Peak, Toseland, & Banks, 1995). The findings of change in only some variables are in keeping with the conclusions of many review studies over the last 15 years that caregiver support groups tend to have small to moderate effects on caregiver outcomes (Coon, Gallegher-Thompson, Thompson, 2003; Kennet, Burgio, & Schulz, 2000; McCallion & Toseland, 1995; Zarit & Teri, 1992). While caregivers generally report high satisfaction with and subjective benefit from interventions, most projects find relatively small to moderate effects of intervention on outcomes measuring general well-being, burden and depression (Bourgeois, Schulz, & Burgio, 1996).

Preliminary findings from research with one of the largest employers of persons who live great distances from their parents, the U. S. military, has suggested that a lack of preparedness for parent care has placed senior ranking military members at higher risk for vocational, family and health related problems (Parker, Call, et al., 2002). Officer satisfaction (N=277) with a "parent-care plan" was inversely related to officer worry even when a variety of other variables were introduced into a structural equation model. This research lends robust, quantitative support to previous qualitative findings by Climo (1992) concerning long distance caregiving, and it further indicates that officer satisfaction with a realistic "parent-care plan" reduces officer worry about their parents.

The finding that satisfaction with parents' future plans significantly reduces adult children's worry over their parent's well-being underscores the importance of parents making and discussing future plans with their children. According to preliminary research, only 8-17 % of the population actively plan for their end-of-life care by talking with their children about their wishes and completing an advance directive (Anthony, 1995; Cugliari, Miller, & Sobal, 1995). Worries about being a burden on their children and difficulty coping with the unknowns of

dying or end of life care cause many parents to avoid making plans or having discussions of plans with children. Further, the prospect of the loss of a parent is traumatic for most children, and initiating a discussion of a parent's end-of-life plans is difficult when a parent insists that there is no need to make plans.

When the family lacks a sense of what the content of a plan should include, and/or parent-child relationship problems exist, adult children often encounter resistance from their aging parents to developing a plan. The parent care planning process, if effectively presented, provides adult children with an opportunity to engage parents in this sometimes difficult, yet critical topic. The process elicits the parents' wishes and desires about medical, legal, environmental, and emotional preferences before the insidious and/or rapid onset of diseases and disabilities that often render parents unable to represent themselves. Adult children and their parents need encouragement and assistance in becoming more intentional in the creation of this individualized family planning guide. Moreover, many adult children lack the motivation to participate in parent care training when their parents are healthy (Parker, 2003). This is unfortunate because most of the tasks associated with the proactive development of a parent care plan are best completed when the parents are able to participate fully in the process (Larimore, 2002). Some parent care tasks legally require the parents' full understanding, participation and sanction (Campisi, Parker, Marson, Cook, & Moore, 2003).

Clergy and other pastoral professionals are uniquely qualified to reinforce the importance of proactive parent care preparation. Like ministers who have been on the forefront of advocacy for premarital counseling, religious leaders can employ their moral authority and utilize religious teachings to underscore the need and methods for families to prepare for the normal, developmental responsibility of parent care. Adult children, spouses, and other family and non-family caregivers involved in faith-based communities can play key roles in maintaining the health and independence of older persons. Religious leaders need adequate training and access to proven resources and methods in order to develop and promote exemplary programs that address these issues.

Recent polls (Binstock, 2002; Brooks & Koenig, 2002) indicate that 95% of Americans aged 50 or older acknowledged belief in God, and that 42-46% of Americans of all ages attended religious services in the past seven days. Despite the fact that religious involvement in America is apparently "alive and well" (Koenig & Brooks, 2002), faith-based communities often lack a vital connection with professional and academic communities–a connection that would help communi-

ties of faith in the development and evaluation of needed eldercare programs. Part of the problem in realizing faith-based potentials in addressing the needs of people (e.g., parent care training) is the common resistance professional and academic organizations have toward recognizing and appreciating the value of spirituality and partnerships with faith-based organizations (The Roundtable on Religion and Social Welfare Policy, 2003). Except for the past two centuries, religion and health professions such as medicine, social work, and nursing were closely linked for most of written history. Unfortunately, it was nearly the end of the 20th century before science began to study the intersection of religion, spirituality, health and aging (Larimore, Parker, & Crowther, 2002).

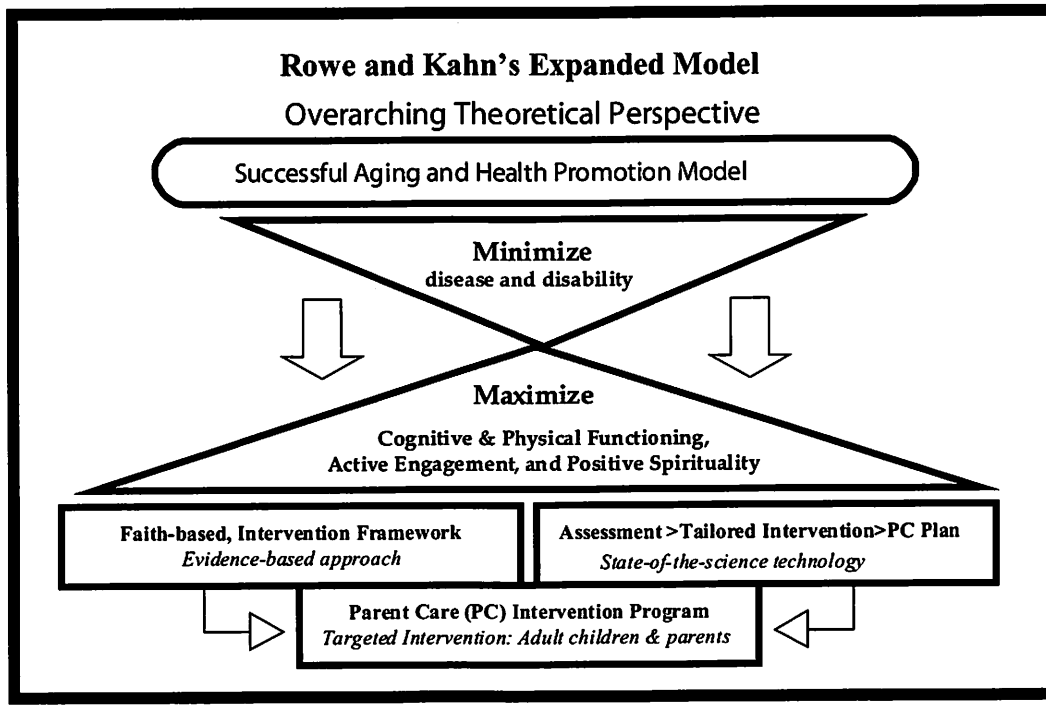
In more recent years, scientists and health care professionals of different disciplines have increasingly acknowledged the strong, positive relationship between faith and health (e.g., Binstock, 2002; George, 2002; Idler, 2002). Research in this area has fostered interest in professional and faith-based collaborations. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), almost three-quarters of U.S. medical schools, and a number of other professional educational programs and organizations provide instruction and practice guidelines on assessing spirituality and incorporating it into clinical care (American Psychiatric Association, 1992, 1995; Council on Social Work Education, 1995; JCAHO, 2001). David Larson's life-time work, recognized by the American Psychiatric Association, calls attention to the general neglect by the research community of spirituality on a variety of physical and mental health outcomes (Larimore, et al., 2002). Though progress has been made since his initial work in the late 1980s, much remains to be accomplished in articulating effective partnerships that address specific needs (The Roundtable on Religion and Social Welfare Policy, 2003). Evidence-based theories are needed as the basis for interventions that bridge these barriers.

A Theoretical Model of Successful Aging

Adult children engaged in parent care require guidelines for promoting their parents' successful aging. Likewise, clergy and lay leaders from faith-based communities are responsible for offering caregiving adults programs and support services that facilitate their expressing the requirements of the role. The primary goal of these programs must be successful aging of older members, and these programs need to be theoretically grounded and include content that is supported by evidence-based guidelines. The theoretical model employed should en-

dorse the proven, scientific importance of spirituality in successful aging. In keeping with the second purpose of this paper, we recommend application of a *modified* version of Rowe and Kahn's (1998) theoretical model of successful aging, as illustrated in Figure 1, because it acknowledges the role of spirituality and thereby facilitates faith-based partnerships and is congruent with scientific findings (Crowther, et al., 2002).

Figure 1



The theoretical incorporation of spirituality into Rowe and Kahn's (1998) model of successful aging represents an important scientific acknowledgement of the research findings of the past four decades. In keeping with this expanded model, Crowther et al. (2002) defined "positive spirituality as a developing and internalized personal relation with the sacred or transcendent that is not bound by gender, race, ethnicity, economics, or class and as a dynamic that promotes the wellness and welfare of self and others." The addition of positive spirituality to Rowe and Kahn's model of successful aging bridges the gap between theory and practice at a time when creative solutions that include spiritual communities, are being sought to address multiple problems.

Faith-based communities can apply this definition and the expanded model as they develop parent care training programs that help older mothers and fathers. That is, the parent care ministry should address these outcomes for the parent and the caregiving adult: (a) to maximize their cognitive and physical fitness, (b) to avoid disease and disability, (c) to remain actively engaged in life, and (d) to experience *positive* spiritual growth. Religious leaders can apply this evidenced-based, four-fold, theoretical model to assist adult children and their parents in understanding the interdependent biological, psychological, social, and spiritual processes associated with aging and their connections to the development of an effective parent care plan. For example, the model and definition of positive spirituality encourages active engagement in life. Parent care plans should encourage the active involvement of older persons in the lives of their families and communities. Parent care plans should affirm the traditional leadership roles of older persons in religious communities. "So even to old age and gray hairs, O God, do not forsake me, till I proclaim thy might to all the generations to come (RSV, Psalm 71: 18)." If properly developed, these plans can provide an important message to adult caregivers that their care is related to their own physical, emotional, and spiritual development and to older persons that their late life contributions and leadership are not just needed, but essential to the welfare of the larger community (Parker, 2003).

A Framework for Faith-based Interventions

A third purpose of this paper is to provide religious leaders with a proven framework for developing and implementing a parent care intervention program. Fortunately, the faith factor (spirituality) has been increasingly incorporated into theoretical models of intervention with older persons and their families (Koenig & Brooks, 2002; Okwumabua & Martin, 1997; Smith & Merritt, 1997). Parker, Bellis, et al. (2002) and Parker, Koenig, et al. (2003) described a community, faith-based framework for conducting interventions with older persons and their families. We highlight this particular approach because it provides a unifying framework that fosters interdisciplinary partnerships between religious, medical, social work, and academic communities that are essential for developing a robust, comprehensive parent care program. In addition, this framework uses Rowe and Kahn's (1998) theoretical model to promote life style changes and individual and corporate forms of spirituality.

The parent care intervention program that follows is based in part

on a military paradigm that can be easily applied and tailored to meet unique congregational contexts, using Rowe and Kahn's (1998) expanded theory of successful aging (Crowther, et al., 2002) and Parker, Bellis, et al.'s (2002) community-based framework as the conceptual contexts for intervention.

Parent Care Intervention Program

The fourth objective of this paper is to describe a specific parent care intervention program that can be used in communities of faith in accordance with the previously described theoretical model and framework for conducting faith-based partnerships. This program is based in part on a military parent care program aimed at increasing officers' readiness to care for parents (Parker & Martin, 2003).

All military personnel with dependent family members are required to complete, prior to deployment, a family care plan that makes provision for the medical, legal, and spiritual welfare of surviving family members if the service member–soldier, sailor, airman, or Marine–does not return. The lead author has advocated before Congress that the traditional composition of the military family care plan must be expanded to include provision for the aging parents of military personnel. The family care plan that the U. S. military uses to assist surviving family members is being modified in clinical studies to include older and disabled loved ones (Parker, Roff, et al., 2003). Leaders from faith-based communities can benefit from lessons now being learned from military families as they strive to help their members develop a family care plan that includes older loved ones.

Parker (2003) developed tools to help military officers and their parents complete a parent care plan. The purpose of the study was to test the efficacy of the assessment and workshop and educational materials in helping adult children complete specific parent care tasks, and thereby improve their readiness to meet current and future parent care responsibilities. A Parent Care Readiness Assessment (PCRA) instrument was developed to determine the degree of preparedness of military personnel. It was administered to 50 military midlife careerists currently stationed at the U.S. Air War College, Maxwell Air Force Base. Using a 2 X 2 randomized, partial crossover design, military participants (N=50) were randomly assigned to experimental (n= 25) and control (n=25) groups. Experimental group members received a two-hour workshop that addressed medical, legal-financial-insurance, family/social, and spiritual/emotional tasks, and accompanying support materials (CD-ROM and workbook materials). Both groups com-

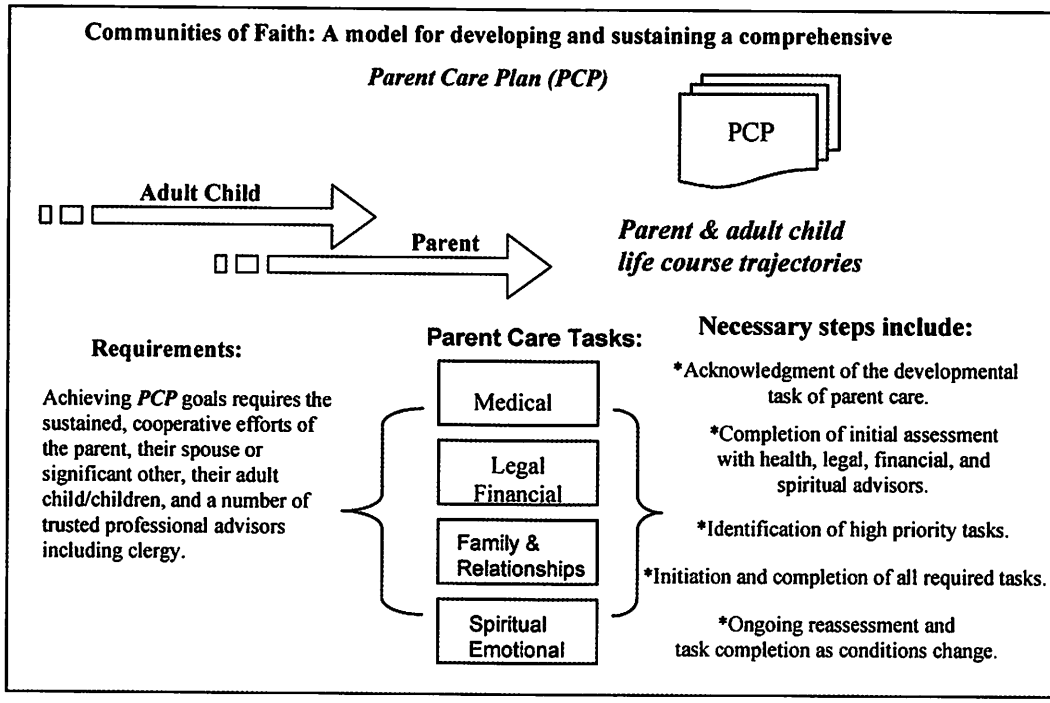
pleted the PCRA at baseline and at a 3-month follow-up. Preliminary results from ongoing field trials suggest that those who participated in the workshop and received the support materials completed more parent care tasks and exhibited higher levels of parent care confidence than the control group.

Communities of faith can adapt the parent care intervention program developed for military families to prepare congregational families to make conscious, informed choices related to the completion of specific and critically important parent care tasks.

The Parent Care Readiness Intervention Program & Planning Process

The proposed Parent Care Readiness Program (PCRP) is intended to connect leaders in communities of faith and families with resources and information related to parent care. It provides practical information to help families successfully meet the challenges of filial responsibility across the core areas in a comprehensive *parent care plan* (PCP) (Martin & Parker, 2003). An overview of the process of completing a PCP is provided in *Figure 2*. Developing a PCP involves completing a

Figure 2



series of specific tasks viewed as most important and relevant to older adults, their family members, and geriatric consultants of different disciplines. Although the intervention has expected outcomes (completed tasks), it is best understood as a dynamic process that involves the completion of specific tasks, and a continuous reassessment and appraisal as circumstances change.

The tasks of parent care (See Table 1) are organized into four domains or categories: medical, legal-insurance-financial, family-social, and spiritual-emotional tasks (Crowther, Baker, Larimore, Koenig, & Parker, 2003; Roff, et al., 2003). Each domain reflects a set of real life challenges (specific parent care tasks) that potentially comprises an important aspect of a parent's care plan. Time management and problem-solving strategies recommend that complex challenges be broken down into essential elements, task by task–so that realistic progress can be made, and so that the person completing the tasks is not overwhelmed with the breadth of the job role (Martin & Parker, 2003). This model underscores the importance of assessment in all four domains and the necessity of a tailored intervention strategy that provides assistance in completing the high priority tasks. The tailoring process minimizes the "smorgasbord" approach because only information and resources appropriate for the task at hand are provided. The primary focus of the intervention is the completion of highest priority tasks in a timely manner. In this context, timely professional consultation adds additional precision to the assessment and intervention process. This process accentuates the preferences of mother and father because the goal is preparation and readiness. Further, the model is best understood as an ongoing process that involves reassessment of completed and uncompleted tasks as the functional and health status of the elder changes.

The principal elements of the parent care program are:

1. PCRA that evaluates the parent care readiness of a family and provides tailored information to address the unique needs of a family;

2. A Parent Care Resource Guide and workbook;

3. A CD-ROM that provides automatic Internet links, resources and information that aid the caregiver in the completion of each task;

4. A two or five-hour workshop curriculum (power point presentation that incorporates selected clips from Hollywood movies and television programs) that augments and incorporates the PCRA, CD, and other resources in an overview of medical, legal-financial-insurance, family, and spiritual tasks; and

Table 1: Parent Care Categories and Sample Associate Tasks

Legal-Financial Tasks	Medical Tasks	Social-Familial Tasks	Spiritual-Emotional Tasks
Discuss with parents the need to complete each of the following documents related to estate dispersion and management, advance directives, etc.	Discuss with your parents how involved or knowledgeable s/he would like you to be about their health, medications, and functional status.	Together with your spouse clarify your own values about where parents' care fits with your other life responsibilities.	Make "peace" with your parents.
Estate Dispersion: • Will • Joint Ownership and Tenancy • Trust/Revocable living trust • Durable Power of Attorney • Preferred possession list	Obtain access to results of comprehensive geriatric assessment.	Assess your relationship with your parents, siblings and other relatives who would be an acceptable and realistic resource for your parents' care.	Secure a video or oral history from your parents.
Advance Directives: • Health care proxy • Do not resuscitate orders • Living Will	Log information acquired from medical appointments.	Convene a family conference to formulate plans. Address who can and will do what, when, and how for your parents.	Investigate the nature of religious programs for seniors available for your parents in their home community.
Secure accessible location of legal documents.	Compile a list of parents' health care providers and telephone numbers.	Know the name, address, email, and phone number of 3 people who live near your parents and who you could telephone if required.	Establish an active prayer life with your parents, and cultivate prayer time with them by phone.
Rule out legal dependency of parents as a way to secure medical and treatment options.	Complie a list of your parents' current medications and obtain a copy of current medical records.	Develop a plan that would allow your parents to remain safely in their home and a plan that includes a move to another location if this becomes necessary.	Identify your parents' wishes for funeral and burial or cremation. If pre-need plans have been made, locate the documentation.
Assist parents in identifying assets, liabilities, income, and expenses.	Verify that primary care doctor or pharmacist is monitoring medications.	Discuss with your parent the possibility of a "panic" button service.	Have a reliable point of contact with at least one member of your parents' church, synagogue, mosque, or religious organization.
Check parents' social security care for accuracy and review parents' credit history (and make sure mother has access to joint or separate credit).	Maintain a list of local emergency service providers (addresses, telephone numbers).	Understand long-term care options available in your parents' home community (living options, in and out of home services.	Encourage your parents to complete a codicil to their will that represents what s(he) would like to say to the next generation.
Investigate the costs of long term care scenarios (e.g. long term care insurance, savings).	Complile a list of services and programs that encourage successful aging practices and suggest appropriate parental involvement.	Evaluate the safety of your parents' home situation (falls, isolation scams), and employ appropriate strategies to increase safety.	Understand hospice and palliative care so as to assist your parents in the death and dying process if it becomes necessary.
Determine the full extent of your parents' health/ life insurance coverage, as well as Medicare and Medicaid entitlements.	Identify signs that indicate your parents can not live independently.	Discuss the feasibility of a driving assessment.	Encourage your parents' faith.

5. Individual family consultation as needed by local professionals (e.g., social workers, geriatric care managers, elder law attorneys, and geriatricians).

Parent Care Readiness Assessment (PCRA)

Perhaps the single most important feature of the parent care training program is the assessment process (Parker, 2003). The PCRA assists a family in identifying and prioritizing specific tasks associated with providing care to their aging family members. Incorporating feedback acquired from focus group sessions with interested volunteers from the U.S. Army and U.S. Air War Colleges and from professional experts from a variety of fields, a 50-item PCRA was developed. Preliminary measures of internal consistency and the degree of fit of the tasks by domain were reported at acceptable statistical levels (Parker, Roff, et al., 2003).

The PCRA provides the caregiver with a sense of priority regarding each task (level of importance), and it identifies for the caregiver those tasks that could have been completed more effectively. Examples of tasks include helping parents develop a list of their health care providers, discuss the advantages and disadvantages of completing a durable power of attorney, and convene a family conference to formulate care plans. Further, it underscores those tasks that need to be completed, and a sense of when these tasks should be completed. The PCRA provides caregiver(s) and care recipient(s) with tailored outcomes based on the assessment process that address each family's unique needs and proclivities.

Participants

Depending upon resources, anyone who would like to attend the workshop should be welcomed because parent care represents a responsibility almost everyone will face over their own life-course. Particular groups are even more likely than others to face this life task. Women, the traditional caregivers, have increasingly entered the work place, placing them at increased jeopardy for burden and burnout (Abel, 1991). Women (wives, daughters, and daughters-in-law) have traditionally provided approximately 70% of home care for ill and disabled family members. About 40% of women providing care to aging relatives may also be providing care to children at the same time, often because of delayed childbearing as well as concurrently caregiving with

a grandparent. As a general guideline, the effects of parent care are most apparent for adult children at midlife because they are at higher risk of facing parent care crises due to the age of their parents. Adult children of frail, community dwelling elderly are at particular risk of having to react to a health care crisis (e.g., a fall or stroke). We are currently testing the value of having parents participate in the training with their adult children, because their participation in planning their own care clearly may have some advantages that should be explored (e.g., self-care and aid to communication). Small congregations with more limited resources should consider forging partnerships with other religious groups, professional organizations, academic institutions, and subject matter experts in developing initiatives. Denominational and other congregation-serving organizations may want to initiate a parent care training programs for congregations.

The participation of local subject matter experts in the training process is encouraged. Their participation can augment and support the specific workbook content. In order to obtain maximum benefit from their participation, the expert(s) should share the comparable spiritual beliefs and practices of sponsoring organization, should be familiar with the parent care training program and with the entire parent care program. The workshop materials correspond to the PCRA and the information on the Parent Care CD-ROM.

Parent Care CD-ROM

This parent care program includes an intervention strategy that takes advantage of computer and Internet technology as a resource and as an intervention strategy. As Internet technology rapidly improves, access to this technology will continue to increase. Interventions using this medium have a strong potential to significantly reduce caregiver burden among adult children who live both close and long distances from their aging parents and to enhance their aging parents' quality of life. A high percentage of seniors will rely on the Internet to communicate with others as costs decrease and ease of use improves. Interactive health communications that can take advantage of this distribution system will be important components of future support services. Families would immediately have ready access to resources that address the most immediate care needs such as locating home health care or adult day care venues. The CD-ROM designed for this intervention program offers information that can be downloaded to address the informational requirements of a specific task. For example, if a family identified Task 1, *completion of a geriatric assessment*, at the touch of a finger,

critical information related to the completion of this task is immediately downloaded for the caregiver and care recipient. Hard copies of information are also provided.

Faith-based organizations can provide computer access and computer training as an incentive to participate in the program. Many parents who are not computer literate would benefit from Internet and Web access. One aspect of their parent care plan might be daily or weekly communication with their more computer literate, adult children and grandchildren via an Internet site at their respective church, synagogue, or mosque.

Conclusions and Implications

How are families, the primary caregivers of older Americans, and faith-based communities in the U.S. going to collaborate with professionals of different health-related disciplines to meet the current and expanding challenges associated the aging population in the U.S.? More specifically, how can religious leaders help prepare families for the responsibilities and religious duties of caring for their parents?

Though it is impossible to prepare fully for the consequences of unforeseen events (e.g., acts of terrorism like the events of 9/11/2001), military families have already taken steps through intergenerational family care plans to reduce the long-term consequences of these and other traumas on their families. In a like manner, religious leaders can help their congregations to be more prepared for the unpredictable (acts of terrorism, auto accidents, health crises) by being more prepared–*ready*–for the predictable, important challenges of life, like parent care. Organized religious communities are consummately suited to underscore the prominence of parent care as a normal role that requires proactive preparation as a religious privilege; and to insure that faith-based programs are made available to prepare families for the developmental task of parent care. This program could become one of organized religions' contributions to homeland and family security.

The unifying framework described and the theoretical basis for the intervention, coupled with the demographic imperative for faith-based parent care interventions, marks a needed reversal in the trend towards separation of spirituality, organized religion, non-faith-based institutions, academia and health care professionals that has occurred over the past several years. This program seeks to prepare adult children for the developmental task of parent care, and thereby limit caregiver worry while enhancing parent care confidence through the proactive completion of specific caregiving tasks. This program is aimed at applying 21st

Century information and service technologies in preparing families to honor their mothers and fathers (or other relatives) in late life with intelligent and loving care. In addition, improved caregiving readiness will allow members of faith-based organization to remain productively employed or engaged in volunteer services and activities, while the effects of their parent care plan will result in a higher quality of life for their older loved ones.

As our aging society faces the growing costs of health care, it will be forced to look with the religious community and the health care industry for creative methods to address the coming health crisis. How will the aging church respond? Our program, which utilizes the expanded Rowe and Kahn (1998) theory and faith-based community framework, has the capacity to generate interest and collaborations across religious (and denominational) lines, racial, and class barriers. This process can help to unify the communities of faith around the important task of "honoring mother and father." This century will bring a growing realization within the health care industry and among religious organizations that the spiritual dimension of people can help bridge the gap between our medical discoveries and how we live.

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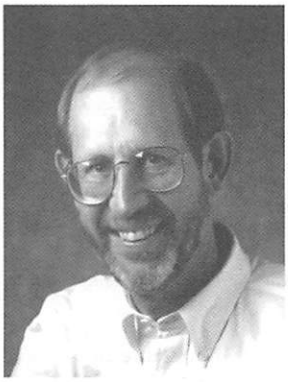
FM snapshot

One Congregational Model for Older Adult Caregiving

John Coulombe



The author provides the reader with an array of ministry possibilities that embody Christ's love for aging families and model how the biblical mandate to care for our older loved ones can be lived out through congregational responses. He notes that caregiving is a significant area of ministry within the church, and churches, including his own, are playing an important role in augmenting senior adult care.

As we go through middle-essence, our children go through adolescence and our parents head into convalescence, the sandwich generation often turns into a "hoagie." What goes for the home also goes for the church. God has given us the ideal design for handling the challenge in which we often find ourselves when caring for our older loved ones, both within the family as well as in the church. The biblical mandate is clear:

> Ps. 71:17-18 "...even when I am old and gray, O God, do not forsake me, until I declare Thy strength to this generation..."
>
> Eph. 6:2-3 "...Honor your father and mother (which is the first commandment with a promise—Ex. 20:12; Deut. 5:16), that it may be well with you, and that you may live long on the earth (Matt. 19:19)."
>
> James 1:27 "This is pure and undefiled religion in the sight of our God and Father, to visit orphans and widows in their distress and to keep oneself unstained by the world."

I am offering an array of ministry possibilities that embody Christ's love for aging families and model how the biblical mandate can be lived out through congregational responses, drawn from the ministry of First Evangelical Free Church of Fullerton, California (EV Free). I do not mean to suggest, however, that EV Free of Fullerton is a "model" church in this arena. Instead I provide this quick reminder. Webster's dictionary definition for the word *model* is: "small imitation of the real thing!" Christ must be our model for ministry (Is. 61; Lk 4:16-22), not the church, but there is much we can learn from each others' experiences as we continue to figure out how to 'do' church according to Christ's model. Many folks still remain untouched within our com-

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Key Words: caregiving; ministry models; service