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The Role of Spirituality in Healthy Aging

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Interest in the association between religion/spirituality and health in later life has heightened in recent years (Coleman 2005; Koenig et al. 2001). Although this interest, broadly defined, crosses all age groups, many studies and writings have focused specifically on the elderly. At least two factors may have driven the increased attention toward religion/spirituality and its relationship to health in later life. First, the longtime boundary between the medical profession and the religious or spiritual has been blurred if not erased. Physicians and other health care professionals have been encouraged to explore the beliefs and religious practices of their patients as a means to better relate to their patients and to increase their understanding of the interactions between these beliefs/practices and their patients' health. For example, diet and lifestyle for some religious groups, such as the Seventh-day Adventists, are strongly determined by the traditions of their faith. Working within those traditions to encourage a healthy diet not only facilitates the therapeutic bond; it also can promote better health (as the Seventh-day Adventists almost completely abstain from smoking and tend toward a vegetarian diet).

Second, the explosion of empirical research about the association between health and the individual's deepest spiritual beliefs, religious practices, and membership in faith communities has been weighted toward the elderly. The reasons for the emphasis on the elderly are not entirely clear but

some factors do emerge. Many large community surveys of older adults, such as the Established Populations for Epidemiologic Studies of the Elderly, have included items assessing religious beliefs and practices (Cornoni-Huntley et al. 1990; Koenig et al. 1999). In addition, it is possible that investigators who have an interest in the elderly also tend to have more of an interest in religion and spirituality. Regardless, the literature exploring the association between religion/spirituality and health among the elderly has significantly increased during the past 20 years.

Yet another factor has emerged. Given the tendency in years past to consider aging from a perspective of inevitable decline and loss, a new paradigm emerged during the 1990s—the concept of successful aging. The MacArthur Research Network on Successful Aging is but the most prominent of a number of efforts supporting this new paradigm. Changes in diet and exercise, mental stimulation, self-efficacy, and dynamic social network connections have all been demonstrated to enhance physical, mental, and social well-being among the elderly. This view has naturally attracted further elaborations of what it means to age successfully. One such elaboration has been proposed by Crowther and colleagues (2002). “Positive spirituality,” according to these authors, is defined by “a developing and internalized personal relation with the sacred or transcendent that is not bound by race, ethnicity, economics, or class and promotes the wellness and welfare of self and others” (p. 613). Such positive spirituality is less authoritarian, less formal and orthodox. It is more intrinsic, oriented toward emotion and behavior and the capacity to engage in positive actions that promote life-enhancing behaviors and beliefs. Although this construct has yet to be demonstrated to be associated with healthy aging, the intuitive appeal of the construct is apparent.

In this chapter we present an exploration of spirituality and healthy aging from three perspectives. First, we explore briefly the data-based studies that have emerged over the past three decades that inform our understanding of the association between religion/spirituality and health among older adults. Second, we reflect on the role of faith communities as they support and at times hinder the health of older adults. Finally, we explore the unique aspects of spirituality among adults entering the later stages of their lives.

Because the vast majority of older adults in North America who are religious adhere to Jewish or Christian tradition (though religious diversity has become much more apparent in Western societies), and because the vast majority of the empirical studies that have explored the association of religion/spirituality and health have been limited to populations from these traditions, most of our discussion in this chapter falls under the canopy of these traditions.

Throughout this discussion, we do not attempt to artificially define and delineate spirituality and religion, for practical and conceptual reasons. Nev-

ertheless, operational definitions of religion and spirituality might at least set parameters for the discussion below. One example is to define religion as an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent and to foster understanding of one's relationship and responsibility to others living together in a faith community. Spirituality, in contrast, may be said to encompass religion but to expand the above definition as an understanding of answers to ultimate questions about life, its meaning, and one's relationship to the sacred or transcendent. Spirituality, therefore, may or may not lead to or derive from the development of religious rituals and the formation of faith communities (Koenig et al. 2001). Unfortunately, such definitions leave much to be desired. For example, some religions do not focus on the transcendent, nor do all spiritual experiences attempt to answer ultimate questions.

Empirical Evidence for the Association Between Spirituality and Health Outcomes in Aging

Empirical studies have explored the association between religion/spirituality and health outcomes (both physical and psychological health). We describe some representative studies briefly below. In general, these studies support an association between participation in religious activities (e.g., church attendance) and better health outcomes, even when baseline health is controlled for. In contrast, studies that explore the association between private religious activities and general measures of spirituality (often measured by a generic scale of spirituality) have been equivocal in their results, strongly supporting neither an association nor the lack of an association.

For example, Markides (1983) examined the relationship between religiosity and life satisfaction in a 4-year prospective cohort study involving older Mexican Americans. He found that church attendance assessed in cross-sectional analyses correlated positively with life satisfaction for both Mexican Americans and Anglos. In contrast, self-rated religiosity and private prayer were correlated with greater life satisfaction for Anglos.

Musick (1996) examined the relationship between religious involvement and subjective health. For African Americans, religious devotion, which included private prayer and Bible reading, was significantly related to subjective health 4 years later. Though religious attendance was related to subjective health cross-sectionally, it dropped out as a predictor of longitudinal subjective health when results were controlled for functional disability. In yet another study, an early study in this field, church attendance was

not associated with life satisfaction in later life but was associated with life satisfaction at an earlier age (Spreitzer and Snyder 1974).

The association between religious activity and well-being may be influenced by the perceptions of older adults versus the perceptions of those who work with them. For example, Carp (1974) examined the relationship between church attendance and adjustment among older adults when they relocated from their homes to a new living situation. Although church attendance was a strong predictor of adjustment as judged by administrator evaluations, attendance was not one of the primary predictors of happiness when rated by the subjects themselves.

Many studies have emerged that inform us about both religious beliefs and practices in relationship to health outcomes. Progress in science, however, is iterative, and equivocal results often signify the need to explore the subject more thoroughly, employing conflicts from previous findings to construct better-designed studies (Blazer 2007). Despite the numerous articles that have emerged, the empirical study of religion remains an infant science. More sophisticated methods will be developed over time to better explore this subject.

Studies of religion and health, however, may stimulate a strong visceral response, a response that may be negative or positive (Blazer 2007). One reason for such a response is the predetermined views of many who assess the salutary benefits of religious beliefs and practices for health. Strong proponents of the health benefits of religious practices, such as Larry Dossey, boldly assert that a practice such as prayer has unquestionably been proven to be as valid and vital to healing as drugs or surgery, having perhaps distorted the understanding of prayer as embodied within most major world religious traditions (Dossey 1997). At the opposite pole, critics such as Richard Sloan have challenged all religions and the entire health research enterprise, claiming that proven curative powers remain to be demonstrated in practice (and therefore medical practice has been contaminated by unproven "spiritual" approaches to treatment), while failing to note that the most significant findings regarding the association between religion and health have not been made in clinical samples (Sloan 2006). Of course, such extreme views are frequently driven by the long-standing personal beliefs of those who assert their views forcefully with limited evidence or communal deliberation. Investigators with a strong personal faith and belief in the positive health benefits of faith bring to the task a very different orientation (and perhaps even different methods) than investigators who are nonbelievers and express strong claims about the damage and danger of religion. The upsurge of interest in religion/spirituality in the United States in general has been countered with an upsurge in vigorous opposition, such as Richard Dawkins' book *The God Delusion* (Dawkins 2006).

Even among believers, however, concerns have been expressed about the appropriation of religion as a “means to an end,” namely health (Shulman and Meador 2003). One’s spirituality and religious practices should be an end in themselves. Popular culture’s fascination with the health benefits of religion runs against the grain of the world’s great religious traditions. A utilitarian view of faith misrepresents and devalues the true meaning of faithfulness in major world faith traditions. Spiritual formation, or simply learning to be religious, does not mean enlisting faith as a vehicle to obtain what one wants, but rather living in a spirit of gratitude and hope. To put this another way, the suffering that may emerge from the inevitable illnesses and loss of function with age may provide an opportunity for growth, perhaps growth through increasing trust and release.

Faith Communities

Spiritual Formation, Attachment, and Healthy Aging

Despite the emergence of a more individualistic approach to spiritual exploration and development (such as a focus on prayer and meditation), Jews and Christians did not exist *per se* prior to and do not exist apart from the society that is called Israel or the Church, respectively (Shulman and Meador 2003). Yet religious communities take on a special character apart from people’s interactions in the workplace or neighborhood, and even within the family. Pollner (1989), in a secondary analysis of data from the National Opinion Research Center General Social Survey, proposes that although the social support literature focuses on the effects of networks composed of “real” or concrete individuals on psychological well-being, persons interact intrapersonally as well with a wide range of others who may or may not actually exist, which is irrelevant to the potential benefits of such interactions. That is, adults identify and form relationships with spiritual or divine beings. Pollner examined the extent to which relationships with “divine others” affect psychological well-being. These relationships had a significant effect on several measures of well-being in controlled studies that included church attendance. These “imaginary social worlds” not only unify one’s beliefs; they also enhance actual social attachments.

Caughey (1984), supporting the role of “divine others,” suggests that we all create imaginary social worlds (and faith communities are almost always in part imaginary social worlds). Some individuals, for example, construct elaborate and enduring, even though perhaps imagined, relations with televangelists and turn to them for guidance and support. Religious texts and symbolism provide many resources for personifying the divine (such as “my Father”), who can then be engaged interactionally for support, guidance, and

solace. The divine other is the most persuasive symbolic “other” in American society. (Additional symbolic “others” might include the government or the military.)

Spirituality and Clinical Indicators of Health

Maselko and colleagues (2007) demonstrated the unique value of the faith community beyond traditional social support. They found that weekly religious attendance was associated with a lower allostatic load among women, but not men. (*Allostatic load* is a physiological construct introduced to measure overall physiological wear and tear on one’s body, which in turn may serve as a preclinical marker of pathophysiological processes that precede the onset of disease.) The association could not be explained by traditional measures of social support. The authors suggested that certain rituals and beliefs linked to religious activity (e.g., the deep inner peace that may result from a practice such as meditation or prayer) may shift the physical state from sympathetic to parasympathetic relaxation.

A community of faith may be especially useful for alleviating depression among older people (Blazer 2000). One means by which the religious community can assist depressed persons and help them find a new sense of meaning is by enabling them to tell their story, thus becoming part of the shared story of the community. Vehicles by which storytelling can be accomplished include individual conversations, sharing groups, and even classroom teaching. This storytelling, in turn, helps older people explore who they are. Another means by which the religious community can buffer the pain of depression is by providing a vision for the community that is incorporated by the individual (e.g., a community that endures together). Many religious communities point to a brighter future than current difficulties present. These communities have, through the ages, enabled people of all ages to tolerate individual and group stress. Finally, religious communities can assist depressed older persons by providing a context for understanding the suffering that they may experience either from physical illnesses or from depressive symptoms.

Social Benefits of Spirituality

Faith communities may also provide practical support. This practical support may be especially valuable to the older adult who has little family in the vicinity or whose family is so occupied that they cannot provide the care and support needed. It is not uncommon that members of the faith community know the immediate needs of the older adult better than family members at some distance. In turn, families often rely on members of the faith community to assist them when they are attempting to help the older adult from a distance.

One means by which these communities provide support is through the reinforcement of beneficial rhythms for older adults. If an older adult is isolated, then the weekly (or more frequent) attendance at gatherings of the faith community provides an ongoing and assured opportunity for social support. If the older adult is not able, for physical or economic reasons, to travel to the regular meetings of the community, frequently someone from the faith community provides transportation, and in the process, one-on-one social interaction.

Faith communities also reinforce the natural cycle of work and rest. The practice of the Sabbath (whether a particular day or as a rhythm within life) reinforces that work must be punctuated with rest. In the modern workplace, this necessary rhythm of Sabbath and rest often is disrupted with nonstop, 7-day-a-week activities with one's work. The older adult may feel isolated in her or his inactivity. The Sabbath (as day or practice) is a reminder that one cannot work at a breakneck pace indefinitely. Regular adherence to the Sabbath in turn supports the older person as he or she enters a period when the energy for work declines and work ultimately gives way to retirement, reframing this as a life-giving opportunity rather than a restriction or imposition within the life course.

Finally, faith communities may provide very practical assistance to older adults. One model program is the parish or congregational nurse movement. Nurses jointly trained in pastoral care as well as health assistance and advocacy are employed by faith communities to provide consultation and guidance to members (frequently older adults). In a health care environment where consumers are faced with a dazzling array of choices (choices of the Medicare Part D drug benefit being a prime example) coupled with difficulty accessing primary care (due to the very busy schedules of primary care providers), negotiating the health care system can be daunting to adults of any age, but especially the elderly. The availability of someone working with a faith community, known and trusted by the older adult, can be of great assistance both in meeting medical needs that need not go beyond the encounter with the congregational nurse and as a bridge to the more formal health care environment.

Individual Spirituality

Divine Relations and Healthy Aging

Robert Browning's well-known poem about old age, "Rabbi Ben Ezra, 1864" (Browning 1915, p. 501), is frequently quoted only in part. We are quite familiar with

Grow old along with me!
The best is yet to be,
The last of life, for which the first was made:

Yet the following lines of the poem set the context for the first three lines:

Our times are in his hand
Who saith, "A whole I planned,
Youth shows but half; trust God see all, nor
Be afraid!

In other words, a central reason for "the best is yet to be" is that "our times are in his hand." Spiritual practices, including those relating to the transcendent "other," may become, as one ages, more individualistic, less visible and measurable, more subjective, and more unifying (Crowther et al. 2002). Although perhaps not well documented, many believe that as one ages within a faith tradition, successful aging is accompanied by a more flexible, loving, and less judgmental orientation formed through years of adaptively negotiating the inevitable frailties and vulnerabilities of life.

The belief that religion/spirituality is essential for successful aging has a long history in the United States. From the Puritans, the perception emerged that old age was insupportable without religion (Cole 1992). St. Paul (II Corinthians 4:16) suggested, "Though outwardly we are wasting away, yet inwardly we are being renewed day by day." This led to the Puritans' belief that piety was exempt from the inevitable decline with growing old and therefore buttressed the individual through the loss of function with age (Cole 1992). Oliver Wendell Holmes believed that old age might be a special time for a closer relationship with God (Holmes 1891, as quoted in Cole 1992, p. 157): "We must not make too much of...exceptional cases of prolonged activity... The great privilege of old age is getting rid of responsibilities.... Freed from the harness, an old man could enjoy more intimate relations with his Maker."

One means by which spirituality is thought to enhance one's late life is through the life review. William Adams (1871, p. 10) believed that mature age "is a hill from which one may look in opposite directions—backward (recollecting the many windings of one's pathway through the world, reconciling those memories with humility, acceptance and renunciation)—and forward—the weary pilgrim focusing on the many mansions of his Father's house, where a place is prepared for him."

As noted earlier (see subsection "Controversies in the Study of Spirituality and Health"), however, the objective evidence that a rich inner spiritual life is associated with better health and well-being is not strong. One exception to the equivocal findings to date is the data from the Netherlands (Braam et al. 2008). As part of a pilot project among older adults (age 60 years and older) in the Longitudinal Aging Study Amsterdam, a small sample of older church members filled out a questionnaire that included items exploring feelings about God and perceptions of God. Feelings of discontent toward God corre-

lated positively with feelings of hopelessness, depressive symptoms, and feelings of guilt, and also with depressive symptoms assessed 13 years earlier. These findings were limited to Protestant participants. In general, positive feelings toward God—perceptions of God as supporting and accepting—were more prevalent than their negative counterparts. There was a trend in this study (not statistically significant) for perceiving God as supportive being associated with lower levels of hopelessness. More support was found for feelings of discontent toward God being associated with higher levels of hopelessness, more depressive symptoms, and more feelings of guilt. One critique of these findings is that they were cross-sectional and that, therefore, for example, depression could lead to feelings of discontent toward God.

In addition, when one is interpreting these results, it should be remembered that both discontent toward God and depressive symptoms may originate in a shared underlying construct. An emotional interpretation of religiousness is rooted in primary object relations or, more specifically, in attachment relationships. A negative or critical image of God may originate in an insecure attachment relationship. In turn, inconsistencies in earlier relationships could generate insecure attachment capacities, which in turn are related to depression in adulthood.

In the Braam et al. (2008) study, feelings of guilt were associated with negative feelings about God, and with perceiving God as one who punishes. Feelings of guilt, however, were also strongly associated with positive feelings toward God. In other words, some feelings of guilt may be considered as normal phenomena, belonging to a religious view of guilt covered by grace, and may connect with awareness of responsibility rather than being pathological.

In another positive study, Bosworth et al. (2003) assessed 114 older adults (age 65 and older) who completed measures of both public and private religious practices. In this study, religious coping (defined as “how I think about my life as part of a larger spiritual force”; “I work together with God as partners”; and “I look to God for strength, support, and guidance”) was related both cross-sectionally and longitudinally to lower scores on the Montgomery-Åsberg Depression Rating Scale. In contrast, public religious practice, but not private religious practice (such as praying, meditating, or watching or listening to religious programming), was related cross-sectionally to lower scores on the Montgomery-Åsberg scale.

Spirituality and Sense of Meaning, Integrity, and Wisdom in Aging

The work of Erik Erikson provides an excellent approach for understanding the potential problem of meaninglessness in later life (Blazer 2000; Erikson 1963). According to Erikson (1963), individuals negotiate through eight epi-

genetic stages during the life cycle (not simply sequentially, but with certain stages more prominent at certain ages than others). Each of these stages can be described as a tension between a healthy resolution and a pathological resolution. The tension of integrity (an acceptance that one's life fits together through time) versus despair is the unique psychological challenge faced by older adults. Resolution of this conflict leads to wisdom. In a later study, Erikson et al. (1986) found that during the last stage of life, the life cycle "weaves back on itself," leading to integration of hope, will, perseverance, competence, fidelity, warmth, and care. In order to meet and overcome the existential dread of "not being," looming ever closer as one ages, the older person continually integrates previous actions and restraints, choices and rejections, and strengths and weaknesses of the present with the past. Erikson et al. (1986, p. 145) summarizes this as follows: Integration is "the acceptance of one's one and only life cycle and of the people who have become significant to it as something that had to be and that, by necessity, permitted no substitutions."

Whitehead and Whitehead (1982) expanded on Erikson's theory from a spiritual perspective. Integrity is the acceptance of one's one and only life as well as the people who have become significant to it as something that had to be and that, by necessity, permitted no substitutions; that is, affirmation of the given inevitability of one's life course. Such acceptance brings both freedom from one's past and a deeper respect for its power in one's life all the way to the present. This process may begin with forgiveness of one's parents even as one enters late life and the parents have long since been deceased. Forgiveness of one's parents, especially one's father, can have profound spiritual significance for the older adult. Integrity, however, does not eliminate despair. Despair, in fact, may be an appropriate response to one's awareness of the limits of one's life, to the awareness that not all the possibilities of that life have been realized.

Along with integrity, wisdom may emerge (Whitehead and Whitehead 1982). Wisdom may manifest itself as an inclusive understanding, a widening empathy, a broadened appreciation of diversity, and pluralism in both persons and experience. The core of this psychological strength of wisdom is a detached yet active concern with life itself, especially the lives of others. The recognition that death is approaching can liberate one's concern for one's own life. Wisdom born in the struggle for integrity enables the older person to squarely face the human condition. It enables the elderly person to maintain confidence as he or she faces the decline of bodily and mental functions.

Conclusion

Facing inevitable decline with age is perhaps one of the central psychospiritual challenges, especially in a social context that permits little room for anything but optimal performance. Baltes and Baltes (1990) have described

a pattern that includes both declines and continuities as “selective optimization with compensation.” The older person is an active agent who negotiates not only with the outside world but with her or his own abilities and resources to maintain as much satisfaction as possible given the inevitability of decline. For example, the elder who has gained much comfort through life from reading scripture but can no longer read may compensate by asking someone to read to him or her, or by listening to recorded readings of scripture. In turn, if disability limits the ability to attend religious services, then the elder may optimize the development of his or her inner spiritual life.

The struggle to come to some integrated sense of one’s entire life may naturally require an inner search for, or a wish to communicate with, the mysterious, ultimate “other”: to many there can be no “I” without an “other” (Buber 1970). With old age, new possibilities emerge for spiritual growth. One moves beyond a merely deductive and notional dimension of the transcendent (e.g., “I believe that God has a plan for the world”) to an affirmation that evolves from personal experience (e.g., “I have experienced the transcendent other in my own life”) (Whitehead and Whitehead 1982).

Meaning for the older adult leads to questions such as “Of what value am I?” “What does a human life mean?” and “Why must I die?” (Whitehead and Whitehead 1982). In other words, older adults must establish a sense of self-worth that is increasingly less dependent on their productivity or role. Rather, they must reach to a deeper acceptance of their life, and come to terms with the diminution and the losses that come with aging (not simply compensating for them). With most of their lives lying behind them, elders face questions that can produce considerable anxiety, namely anxiety as to what has been significant in their lives. Reputation, accomplishment, duty, influence, affection, and wealth, important sources of self-esteem, may decrease. Paradoxically, these losses may provide an opportunity to recognize the power that these factors held, powers that may not be congruent with one’s sense of a mature spiritual self. This in turn may lead to the affirmation by elders that they are more than what they may seem to others or even previously seemed to themselves. This is an acceptance of one’s particularity, finiteness, and limitations, and moves beyond simple acquiescence toward appreciation and celebration of one’s unique, though limited, self.

KEY POINTS

- Religion is an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent and to foster understanding of one’s relationship and responsibility to others living together in a faith community.

- Spirituality encompasses religion but expands the above definition as an understanding of answers to ultimate questions about life, its meaning, and one's relationship to the sacred or transcendent.
 - Empirical studies support an association between participation in religious activities (e.g., church attendance) and better health outcomes, even when controlling for baseline health, among the elderly.
 - Even among believers, concerns have been expressed about the appropriation of religion as a means to an end, namely health in late life.
 - A community of faith may be especially helpful for alleviating depression among older people.
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