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Rowe and Kahn's Model of Successful Aging Revisited: Positive Spirituality—The Forgotten Factor

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Purpose: We explain a new concept, positive spirituality, and offer evidence that links positive spirituality with health; describe effective partnerships between health professionals and religious communities; and summarize the information as a basis for strengthening the existing successful aging model proposed by Rowe and Kahn. ***Design and Methods:*** A missing component to Rowe and Kahn's three-factor model of successful aging is identified, and we propose strengthening the model with a fourth factor, positive spirituality. ***Results:*** We developed an enhanced model of successful aging based on Rowe and Kahn's theoretical framework. Evidence presented suggests that the addition of spirituality to interventions focused on health promotion has been received positively by older adults. ***Implications:*** Leaders in gerontology often fail to incorporate the growing body of scientific evidence regarding health, aging, and spirituality into their conceptual models to promote successful aging. The proposed enhancement of Rowe and Kahn's model will help health professionals, religious organizations, and governmental agencies work collaboratively to promote wellness among older adults.

Key Words: Religion, Faith-based interventions, Churches, Older adults

The spiritual dimension of older adults has not been integrated into promising intervention models that promote successful aging. The lack of interest in issues of spirituality and aging may be analogous to the unwillingness of older people to act upon or comply with prescribed treatments. "As we find ways to improve the lives of older people and ameliorate the diseases which afflict them, we are also confronted by the reality that we are often unable to successfully utilize these discoveries" (Antonucci, 2000, p. 5).

As a means of consolidating knowledge and practice, the MacArthur Foundation offered a promising set of studies on successful aging. In summarizing the findings, Rowe and Kahn's (1998) model provided scientifically grounded parameters for understanding health across the life course and goals for constructing a framework for interventions. However, despite the advantages of their model, it does not incorporate research in the area of spirituality and health that would strengthen it as a framework for promoting successful aging interventions. This article has two aims. First, to assert that spirituality is an important component of health and well-being outcomes among older adults. Second, to argue for interventions which incorporate spirituality with underserved populations as a guide to health professionals, religious organizations, and governmental agencies.

Clarifying Concepts

Part of the problem with incorporating spirituality into scientific thinking has been the confusion associated with the terms *religion* and *spirituality* (Krause, 1993). When descriptive adjectives like *intrinsic* or *extrinsic* are added, the problem is compounded. Religious variables in early research were typically limited to declarations of nominal religious affiliation or were totally excluded from consideration (Larson, Pattison, Blazer, Omran, & Kaplan, 1986). There is a need to define and distinguish spirituality and religion so that research can proceed with greater clarity and consistency. In support of this clarification, we use definitions offered by Koenig and colleagues (Koenig, McCullough, & Larson, 2000), and we define a new term—*positive spirituality.* The distinctions between

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Table 1. Distinctions Between Religion, Spirituality, and Positive Spirituality

Religion	Spirituality	Positive Spirituality
Community focused	Individualistic	Seeks to identify those features of religion and spirituality that have yielded or are associated with positive outcomes. The blend between community focused and individualism.
Observable, measurable, organized and/or more extrinsic	Less visible and measurable, more subjective and/or more intrinsic	Measurable, extrinsic, and intrinsic
Formal, orthodox, organized	Less formal, orthodox	Less formal, orthodox, and systematic
Behavior oriented, outward practices	Emotionally oriented, inward directed	Emotion and behavior oriented
Authoritarian in terms of behavior	Not authoritarian, little accountability	Accountable to engaging in positive actions
Doctrine separating good from evil	Unifying, not doctrine oriented	Unifying, promoting life enhancing beliefs

religion, spirituality, and positive spirituality are described below and in Table 1.

Religion.—"Religion is an organized system of beliefs, practices, rituals and symbols designed (a) to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality), and (b) to foster an understanding of one's relation and responsibility to others in living together in a community" (Koenig et al., 2000, p. 18).

Spirituality.—"Spirituality is the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community" (Koenig et al., 2000, p. 18).

Positive Spirituality.—Positive spirituality involves 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. Positive spirituality uses aspects of both religion and spirituality. It also incorporates the work of the Fetzer work groups, which suggests that religion and spirituality are multidimensional constructs (Fetzer Institute, 1999). Our focus extends the contributions of the Fetzer work groups, namely, to capture health-relevant domains of religiousness and spirituality, by focusing on *only* positive aspects of spirituality or religion within the context of a conceptual model related to successful aging. The addition of positive spirituality to Rowe and Kahn's model of successful aging helps bridge the gap between theory and practice at a time when the Congressional and Executive branches of the government are enacting rules for collaboration between government and the faith community in serving the poor (e.g., Personal Responsibility and Work Opportunity Reconciliation Act, 1996).

To discuss more fully what we mean, it becomes necessary to address what positive spirituality is not. There is general agreement that certain religious beliefs and activities can adversely affect both mental and physical health (Koenig, 2001). Spirituality may be restraining rather than freeing and life enhancing (Pruyser, 1987). Religious beliefs have been used to justify hypocrisy, self-righteousness, hatred, and prejudice. The aspects of spirituality or religion that separate people from the community and family (e.g., hypocrisy, self-righteousness), or that encourage *unquestioning* devotion and obedience to a single charismatic leader, or promote religion or spiritual traditions as a healing practice to the total exclusion of any medical care, are likely to adversely affect health over time. For example, we would not suggest that Reverend Jim Jones and the Guyana mass suicide of nearly 900 people, the David Koresh cult in Waco, Texas, or the terrorist attack on September 11th that destroyed the World Trade Center Towers were guided by positive spirituality. Many Western and Eastern religious traditions emphasize an intimate relation with a transcendent force, place high value on personal relations, stress respect and value for the self, yet place emphasis on humility. The resulting emphasis on relations—relation to a transcendent force, to others, and to self—may have important mental health consequences, especially in regard to coping with the difficult life circumstances that accompany poor health and chronic disability.

Positive spirituality may reduce the sense of loss of control and helplessness that accompanies illness. Positive spiritual beliefs provide a cognitive framework that reduces stress and increases purpose and meaning in the face of illness. Spiritual activities like prayer and being prayed for may reduce the sense of isolation and increase the patient's sense of control over illness or disease. Public religious behaviors that improve coping during times of physical illness include, but are not limited to, participating in worship services, praying with others (and having others pray for one's health), and visits from religious leaders

such as a chaplain, pastor, priest, or rabbi at home or in the hospital.

Rowe and Kahn's Model of Successful Aging and Positive Spirituality

In their original model, Rowe and Kahn (1987) defined successful aging as the avoidance of disease and disability. More recently they have expanded their model to include maintenance of physical and cognitive function and engagement in social and productive activities (Rowe & Kahn, 1997, 1998), making it ready for future intervention studies (Riley, 1998). However, their notion of successful aging has not been without criticisms.

Rowe and Kahn's (1998) model has been criticized for not emphasizing biological research (Masoro, 2001) and for not including social structure and self-efficacy (Riley, 1998). We argue that the social and biological components to aging successfully are portrayed adequately within the existing model as "avoidance of disease and disability" and "active engagement with life" (Rowe & Kahn, 1998, p. 39). Additionally, we agree with Rowe and Kahn (1998) that self-efficacy, as a psychological construct, properly rests within their original conceptualization of cognitive and mental fitness, and that it does not represent a separate, distinct component to successful aging.

Although we maintain that Rowe and Kahn's (1998) synthesis of the literature addresses these criticisms adequately without necessary modification of their framework, their model falters systemically on two counts. First, their work does not endorse the growing body of research examining the relation between spirituality and health outcomes (see reviews by Levin, 1996; Matthews & Larson, 1995). Spirituality has been associated with an improvement in subjective states of well-being (Ellison, 1991), a reduction in levels of depression and distress (Williams, Larson, Buckler, Heckmann, & Pyle, 1991), a reduction in morbidity, and an increase in life span (Levin, 1996). Second, their neglect of spirituality as a major construct handicaps their call for efficacious applications with their model. National surveys have consistently shown that the vast majority of older Americans, in particular ethnic and minority elders, report a religious or spiritual component to their lives (Princeton Religious Research Center, 1987, 1994).

In the following section, we introduce positive spirituality into Rowe and Kahn's (1998) model, as illustrated in Figure 1. We maintain that this expanded model will enhance the percentage of older adults who age successfully by affirming an important and positive aspect in the lives of many older Americans, while in no way disenfranchising those to whom spirituality is not important. Furthermore, the theoretical incorporation of spirituality into models of successful aging represents an important scientific acknowledgement of the research findings of the past four decades. Rowe and Kahn's model has three components: (a) minimizing risk and disability, (b) engaging in active life, and (c) maximizing physical and mental activities. The three components of the model have the following characteristics: (a) each is a part of an overall system and each is therefore temporally related to the others, (b) the variables are activating characteristics that describe both weaknesses and strengths, and (c) each must consider both individual characteristics as well as contextual factors. We argue that positive spirituality is the missing component in the model; it addresses the interrelatedness between the older adults' beliefs and values, the community, and the efficacy of interventions focused on successful aging.

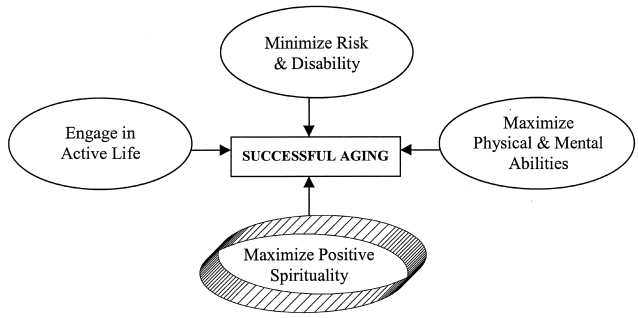

Figure 1. Revised Rowe and Kahn Model of Successful Aging.

Rowe and Kahn (1997) indicated that the stage is set for intervention studies to identify effective strategies that enhance wellness among older adults. We maintain, with our broadened Rowe and Kahn model, that aging is multifaceted and consists of interdependent biological, psychological, social, and *spiritual* processes. Further, we assume that lives are lived within a social and historical context, and that the relation between individuals and society is multidimensional and interactive. For example, positive spirituality fosters active engagement in life, through religious and/or community activities, prayer, meditation, and other practices. In addition, the literature has found an association between spiritual and/or religious activities and the reduction in disability and disease, thus allowing seniors to remain actively engaged.

The intellectual acceptance of spirituality as a major facet of life will help reopen doors of opportunity with groups who have avoided or become reluctant recipients of traditional health promotion interventions. A person's spirituality is not bound by race and socioeconomic status, and its acceptance in theory will provide gerontologists the option of considering spiritual tools and paradigms in designing efficacious, evidence-based health promotion interventions that cut across traditional racial, ethnic, and economic boundaries.

Positive Spirituality and Wellness

Except for the past two centuries, religion and medicine have been closely linked for most of recorded history. Yet until nearly the end of the 20th century, science has not seriously studied the relation between measures of religion, spirituality, health, and aging (Koenig, 1999; McFadden, 1996). Because of the growing recognition that religious and spiritual beliefs and

practices are widespread among the American population and that these beliefs and practices have clinical relevance, professional organizations are increasingly calling for greater sensitivity and better training of clinicians concerning the management of religious and spiritual issues in assessment, treatment, and research (Accreditation Council for Graduate Medical Education, 1994; American Psychiatric Association, 1995; American Psychological Association, 1992; Council on Social Work Education, 1995; The Joint Commission on the Accreditation of Healthcare Organizations in 1996, 2001).

Positive Spirituality, Psychological, and Physical Health Outcomes

There are multiple psychological, social, behavioral, and physiological mechanisms by which religious involvement may impact health and speed recovery from disease. Several researchers have found that religious activity—particularly when it occurs in the setting of community such as involvement in religious worship services—and related voluntary activity is associated with longer life span (Glass, Mendes de Leon, Marottoli, & Berkman, 1999; Hummer, Rogers, Nam & Ellison, 1999; Oman & Reed, 1998). Additionally, several studies have shown a positive association between religious involvement and better adaptation to medical illness (Ell, Mantell, Hamovitch, & Nishimoto, 1989; Jenkins & Pargament, 1995; Kaczorowski, 1989) or to the burden of caring for those with medical illness (Keilman & Given, 1990; Rabins, Fitting, Eastham, & Zabora, 1990). Religious activity has also been associated with better compliance with antihypertensive therapy (Koenig, George, Cohen, et al., 1998).

Religiously committed persons are less likely to engage in health behaviors like cigarette smoking and excessive alcohol use (Koenig et al., 2000). In this way, religion may help to prevent the negative health consequences that follow these unhealthy behaviors. On the other hand, these persons are often involved in close family systems and supportive communities, which may have effects on health through other explanatory mechanisms.

Level of religious commitment also predicts speed of recovery from depression regardless of initial depression severity, an effect that is strongest in those with chronic physical disability that is not responding to medical therapies (Koenig, George, & Peterson, 1998). A positive association between religious involvement and mental health in persons with physical disability has also been found in studies of hospitalized medical patients (Idler, 1995; Larson, 1993). Similarly, studies of mental health and substance abuse have shown that religious activity buffers against the negative effects of physical illness or stressful life events (Kendler, Gardner, & Prescott, 1997). Nearly 850 studies have now examined the relation between religious involvement and some indicator of mental health. Many of the studies have been conducted in medically ill patients or older persons suffering with chronic disability. The vast majority of such studies do indeed find that religious involvement is associated with greater well-being and life satisfaction, greater purpose and meaning in life, greater hope and optimism, less anxiety and depression, more stable marriages and lower rates of substance abuse (Koenig, McCullough, & Larson, 2000).

Religious Coping, Psychological, and Physical Health Outcomes

In an examination of the association between religious coping and depression, Koenig and colleagues (1995) found that religious coping may reduce the affective symptoms of depression, but appeared less effective for the biological symptoms that are probably more responsive to medical treatments. More recently, Koenig and collaborators examined the association between 21 types of religious coping and a host of physical and mental health characteristics (Koenig, Pargament, & Nielsen, 1998). Offering religious help to others (e.g., praying for others) was one of the most powerful predictors of high quality of life, low depressive symptoms, greater level of cooperativeness, and greater stress-related growth. Other types of religious coping associated with positive mental health included reappraising God as benevolent, collaborating with God, seeking a connection with God, and seeking support from clergy or other church members. These coping behaviors were strongly related to stress-related growth, enabling patients to experience greater psychological growth from these stressful health problems. Coping behaviors that focused primarily on the self (self-directed coping) without depending on God, were related to greater depression, lower quality of life, and significantly lower stress-related growth. Some studies show that religious coping is also associated with improved attendance at scheduled medical appointments (Koenig, 1995).

Several studies report an association between religious involvement and immune system function. Dull and Skokan (1995) developed a cognitive model to explain the relation between spirituality and the immune system. In their model they posit that spirituality is a complex system of beliefs that can have an impact on all aspects of an individual's daily life. Spiritual practices may affect a person's cognitions and subsequently impact health practices and outcomes. For example, a cancer patient with spiritual beliefs may assign a larger meaning to the illness, thus reducing the negative effects of stress on health.

Investigations in patients with AIDS show that those who are more involved in religious activities have measurably stronger immune function (Woods, Antoni, Ironson, & Kling, 1999). Likewise, studies at Stanford University in patients with breast cancer show better immune functioning among women with greater religious expression (Schaal, Sephton, Thoreson, Koopman, & Spiegel, 1998). The findings presented above suggest a positive association between religion and reduced levels of psychological stress and could point to physiological consequences that impact physical health as well. However, this research is in its

earliest stages, with the results highly preliminary and not definitive. Prospective studies and clinical trials are needed to determine the order of the effects.

The Role of Positive Spirituality in Health Promotion

Health promotional efforts are designed to transform the more traditional biomedical models that accentuate the physician's responsibility to treat disease, to an ideal in which individuals are increasingly responsible for optimizing their health by attending to the quality of their self-care. Hooyman and Kiyak (1999) suggest that health promotion makes "explicit the importance of people's environments and lifestyles as determinants of their health status" (p. 117). As a reflection of and in reaction to the aging demography of America and the world, the American Association for World Health (1999) has adopted the theme, "Healthy Aging, Healthy Living—Start Now." Practitioners have not used specified exercises for self-care consistently in the development of innovative wellness initiatives (Prochaska & DiClemente, 1984; Prochaska, Velicer, DiClemente, & Rossi, 1993). Only rarely and recently are the implications of these research domains considered in the development of wellness and health promotion programs (Parker, Fuller, Koenig, Bellis, Vaitkus, & Eitzen, 2001).

The National Academy on an Aging Society (2000) has released information that portrays the health promotional challenge with seniors. Almost all of the at-risk conditions are associated with chronic illnesses such as hypertension, heart disease, diabetes, cancer, and stroke. Though many older people are at risk for chronic conditions because of genetic predisposition, gender and age, many risk factors are related to modifiable health behaviors.

Can religious and spiritually minded organizations participate more actively in these efforts? Can they help fill the void in funding of intervention initiatives? We offer evidence to support these assertions. The role religious organizations can play and have played in providing support for aging members in the community and hospital has often been overlooked or not acknowledged in the literature on successful aging. Religious communities have the most valuable resource in society—people. By supporting community-dwelling older adults and their caregivers, religious communities could potentially reduce both the length and frequency of hospital admissions and perhaps delay nursing home placement. Religious denominations, spiritually minded nonprofit organizations, ecumenical groups, churches, synagogues, and other religious institutions represent viable sources that can be engaged in partnerships that provide health promotional and prevention opportunities to groups that are more difficult to reach (Parker et al., 2000; Parker et al., 2002).

Models of Intervention That Incorporate Positive Spirituality

The African American religious community has helped establish the connection between health promotion and spirituality. In their 20-year review of lay health advisor programs among African Americans, Jackson and Parks (1997) reviewed the growing lay health advisor movement. Among their findings was the recommendation that professional educators should rely on the collective wisdom of the community to identify, recruit, select, and train lay health advisors, and they cite a number of studies that confirm the value of seeking the collective wisdom of the African American religious community in health promotional outreach programs.

Smith, Merritt, and Patel (1997) examined the impact of education and support provided by African American churches in encouraging health promotion activities for blood pressure management. In a related program, Kong (1997) described a community-based program, which included churches, that played a valuable role in increasing the number of African American hypertensives that received treatment. There is also evidence that supports the role of ministers in providing assistance for African Americans (Okwumabua & Martin, 1997; Neighbors, Musick, & Williams, 1998).

Jackson and Reddick (1999) describe the Health Wise Church Project, a community outreach initiative between a diverse group of African American churches and a university health education program. The primary objective was to develop early detection and illness prevention networks among older church members. Their four-stage model for the establishment of academic–church collaborations is similar to a model used by Parker and colleagues (2000, 2001), which adopted the Rowe and Kahn model of successful aging with the addition of positive spirituality. As illustrated in Figure 2, we have taken the Parker and colleagues model and adapted it for use with faith-based and non–faith-based organizations. This model is a unifying theoretical framework that fosters interdisciplinary thinking as well as program development and research in the area of health promotion. The model demonstrates how prevention information can be disseminated to older adults by gaining access to community organizations. The inclusion of both faith and non–faith-based organizations captures older persons who consider themselves spiritual but do not associate with organized religion.

The model considers a variety of social, biological, cultural, and economic factors that influence health and health behavior. Experts recommend diet and exercise to alter individual health practices, to create healthier environments, and to enlighten attitudes and expectations toward health (Rowe & Kahn, 1998). By interacting with older adults through faith and non–faith-based organizations as proposed in the model, the more traditional biomedical models that accentuate the physician's responsibility to treat disease are transformed to an ideal in which individuals are increasingly responsible for optimizing their health by attending to the quality of their self-care (Hooyman & Kiyak, 1999).

Faith and non–faith-based organizations can work across denominational and racial boundaries

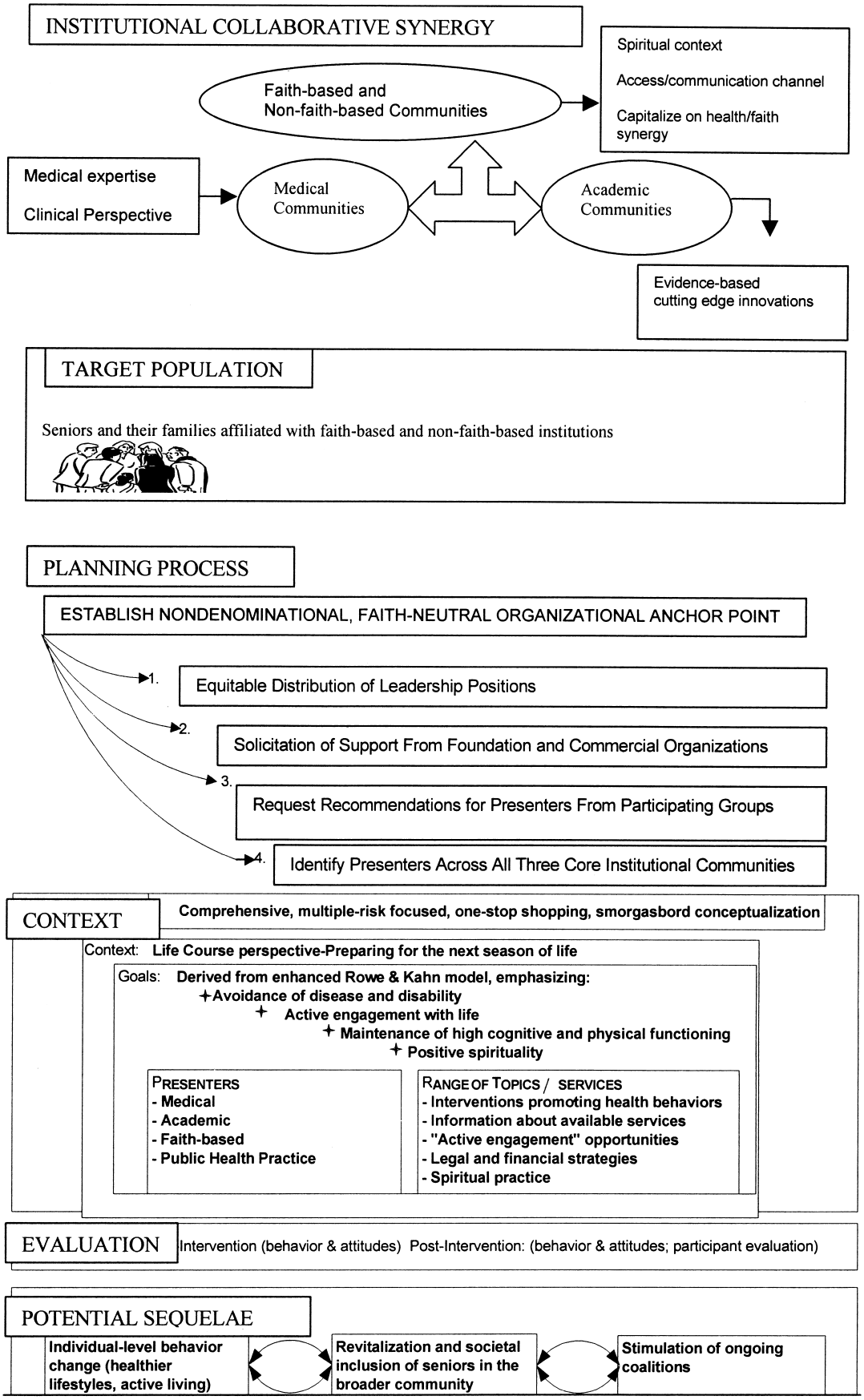

Figure 2. Proposed model for community-level health promotion for seniors.

in conjunction with public and private health care providers and academia and research organizations to forge partnerships. These partnerships can provide the impetus and resources necessary for communities to organize conferences, programs, or workshops that promote successful aging. This model symbolizes the potential of community partnerships in addressing institutional forms of diversity that limit outreach with disadvantaged groups. The unifying framework proposed 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.

Conclusion

We have briefly reviewed studies exploring the spirituality–health connection and its impact on successful aging. This research is in its very earliest stages, with the results highly preliminary and not definitive. Results suggest an association; however, prospective studies and clinical trials are needed to determine the direction of effects. In an effort to build on Rowe and Kahn's (1998) model of successful aging, we offer evidence to include a conceptually distinct category—positive spirituality. The incorporation of positive spirituality into Rowe and Kahn's model of successful aging helps underscore the importance of this area in self-health care. We maintain that all interventions should be sensitive to the diversity of Americans' religious and spiritual beliefs, attitudes, and practices, and spiritual or religious interventions should only be offered with permission, respect, and sensitivity. Any intervention using positive spirituality should be patient- and not caregiver-centered. The health care provider must honor the patient's autonomy, follow the patients' lead and needs, and use permission, respect, wisdom, and sensitivity. We look forward to the continued growth of research as well as more fine-tuning of the implications for interventions.

References

Accreditation Council for Graduate Medical Education. (1994). *Special requirements for residency training in psychiatry.* Chicago, IL: Author.

American Association for World Health. (1999). *Healthy living—start now!* Washington, DC: Author.

American Psychiatric Association. (1995). American Psychiatric Association practice guidelines for psychiatric evaluation of adults. *American Journal of Psychiatry Supplement, 152*, 64–80.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. American Psychological Association. *American Psychologist, 47*, 1597–1611.

Antonucci, T. (2000, April 5). Statements from the candidates for presidency of GSA. *Gerontology News, 5*.

Council on Social Work Education. (1995). *Handbook of accreditation standards and procedures.* Alexandria, VA: Author.

Dull, V. T., & Skokan, L. A. (1995). A cognitive model of religion's influence on health. *Journal of Social Issues, 5*, 49–64.

Ell, K. O., Mantell, J. E., Hamovitch, M. B., & Nishimoto, R. H. (1989). Social support, sense of control, and coping among patients with breast, lung, or colorectal cancer. *Journal of Psychosocial Oncology, 7*, 63–89.

Ellison, C. G. (1991). Religious involvement and subjective well-being. *Journal of Health and Social Behavior, 32*, 80–99.

Fetzer Institute. (1999). *Multidimensional measurement of religiousness/spirituality for use in health research*. Kalamazoo, MI: Author.

Glass, T. A., Mendes de Leon, C., Marottoli, M. A., & Berkman, L. F. (1999). Population based study of social and productive activities as predictors of survival among elderly Americans. *British Medical Journal, 319*, 478–485.

Hooyman, N. R., & Kiyak, H. A. (1999). A multidispciplinary perspective. In *Social Gerontology* (pp. 116–128). London: Allyn and Bacon.

Hummer, R., Rogers, R., Nam, C., & Ellison, C. G. (1999). Religious involvement and U.S. adult mortality. *Demography, 36*, 273–285.

Idler, E. L. (1995). Religion, health, and nonphysical senses of self. *Social Forces, 74*, 683–704.

Jackson, E. J., & Parks, C. P. (1997). Recruitment and training issues from selected lay health advisor programs among African Americans: A 20-year perspective. *Health Education & Behavior, 24*, 418–432.

Jackson, R. S., & Reddick, B. (1999). The African American church and university partnerships: Establishing lasting collaborations. *Health Education & Behavior, 26*, 663–675.

Jenkins, R. A., & Pargament, K. I. (1995). Religion and spirituality as resources for coping with cancer. *Journal of Psychosocial Oncology, 13*, 51–74.

Kaczorowski, J. M. (1989). Spiritual well-being and anxiety in adults diagnosed with cancer. *The Hospice Journal, 5*, 105–116.

Keilman, L. J., & Given, B. A. (1990). Spirituality: An untapped resource for hope and coping in family caregivers of individuals with cancer. *Oncology Nursing Forum, 17*, 159.

Kendler, K. S., Gardner, C. O., & Prescott, C. A. (1997). Religion, psychopathology, and substance use and abuse: A multimeasure, genetic-epidemiologic study. *American Journal of Psychiatry, 154*, 322–329.

Koenig, H. G. (1995). Use of acute hospital services and mortality among religious and non-religious copers with medical illness. *Journal of Religious Gerontology, 9*, 1–22.

Koenig, H. G. (1999). *The healing power of faith*. New York: Simon & Schuster.

Koenig, H. G. (2001). Religion and medicine III: Developing a theoretical model. *International Journal of Psychiatry in Medicine, 31*, 199–216.

Koenig, H. G., Cohen, H. J., Blazer, D. G., Kudler, H. S., Krishnan, K. R. R., & Sibert, T. E. (1995). Cognitive symptoms of depression and religious coping in elderly medical patients. *Psychosomatics, 36*, 369–375.

Koenig, H. G., George, L. K., Cohen, H. J., Hays, J. C., Blazer, D. G., & Larson, D. B. (1998). The relation between religious activities and blood pressure in older adults. *International Journal of Psychiatry in Medicine, 28*, 189–213.

Koenig, H. G., George, L. K., & Peterson, B. L. (1998). Religiosity and remission from depression in medically ill older patients. *American Journal of Psychiatry, 155*, 536–542.

Koenig, H. G., McCullough, M., & Larson, D. B. (2000). *Handbook of religion and health*. New York: Oxford University Press.

Koenig, H. G., Pargament, K. I., & Nielsen, J. (1998). Religious coping and health status in medically ill hospitalized older adults. *The Journal of Nervous and Mental Disease, 86*, 513–521.

Kong, B. W. (1997). Community-based hypertension control programs that work. *Journal of Health Care for the Poor & Underserved, 8*, 401–409.

Krause, N. (1993). Measuring religiosity in later life. *Research on Aging, 15*, 170–197.

Larson, D. B. (1993). *The faith factor: An annotated bibliography of clinical research on spiritual subjects, Volume II*. Rockville, MD: National Institute for Healthcare Research.

Larson, D. B., Pattison, E. M., Blazer, D. G., Omran, A. R., & Kaplan, B. H. (1986). Systematic analysis of research on religious variables in four major psychiatric journals, 1978–1982. *American Journal of Psychiatry, 143*, 329–334.

Levin, J. S. (1996). How prayer heals: A theoretical model. *Alternative Therapy in Health Medicine, 2*, 66–73.

Masoro, E. J. (2001). "Successful Aging"—Useful or misleading concept? *The Gerontologist, 41*, 411–414.

Matthews, D. A., & Larson, D. B. (1995). *The faith factor: An annotated bibliography of clinical research on spiritual subjects, Volume III: Enhancing life satisfaction.* Rockville, MD: National Institute of Healthcare Research.

McFadden, S. H. (1996). Religion, spirituality, and aging. In J. E. Birren & K. W. Schaie (Eds.), *Handbook of the psychology of aging* (4th ed., pp. 162–177). San Diego, CA: Academic Press.

National Academy on an Aging Society. (2000, February). At risk: Developing chronic conditions later in life. In *Challenges for the 21st century: Chronic and disabling conditions*. Washington, DC: Author.

Neighbors, H. W., Musick, M. A., & Williams, D. R. (1998). The African American minister as a source of help for serious personal crises: Bridge or barrier to mental health care? *Health Education and Behavior, 25*, 759–777.

Okwumabua, J. O., & Martin, B. (1997). Stroke belt initiative: The Tennessee experience. *Journal of Health Care for the Poor & Underserved, 8*, 292–300.

Oman, D., & Reed, D. (1998). Religion and mortality among the community-dwelling elderly. *American Journal of Public Health, 88*, 1469–1475.

Parker, M. W., Allman, R., Bishop, P., Thompson, P., Moore, C., Kosberg, J., et al. (2000, April). *Summer camps for seniors: A multidisciplinary intervention advocating successful aging and spirituality.* Paper presented at the Southern Gerontological Society Conference, Raleigh, NC.

Parker, M., Bellis, J., Harper, M., Bishop, P., Moore, C., Thompson, P., et al. (2002). Multidisciplinary model of health promotion incorporating spirituality into a successful aging intervention with African American and White elderly. *The Gerontologist, 42*, 406–415.

Parker, M., Fuller, G., Koenig, H., Bellis, J., Vaitkus, M., & Eitzen, J. (2001). Soldier and family wellness across the life course: A developmental model of successful aging, spirituality and health promotion, part II. *Military Medicine, 166*, 561–570.

Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104–193, §104, 110 Stat. 2105 (1996).

Princeton Religious Research Center. (1987). *Religion in America*. Princeton, NJ: Gallup Poll.

Princeton Religious Research Center. (1994). Importance of religion. *PRRC Emerging Trends, 16*, 4.

Prochaska, J. O., & DiClemente, C. C. (1984). *The transtheoretical approach: Crossing traditional boundaries of therapy.* Homewood, IL: Dow Jones/Irwin.

Prochaska, J. O., Velicer, W. F., DiClemente, C. C., & Rossi, J. S. (1993). Standardized, individualized, interactive and personalized self-help programs for smoking cessation. *Health Psychology, 12*, 399–405.

Pruyser, P. W. (1987). Where do we go from here? Scenarios for the psychology of religion. *Journal for the Scientific Study of Religion, 26*, 173–181.

Rabins, P. V., Fitting, M. D., Eastham, J., & Zabora, J. (1990). Emotional adaptation over time in care-givers for chronically ill elderly people. *Age and Ageing, 19*, 185–190.

Riley, M. W. (1998). Letter to the editor. *The Gerontologist, 38*, 151.

Rowe, J. W., & Kahn, R. L. (1987). Human aging: Usual and successful. *Science, 237*, 143–149.

Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist, 37*, 433–440.

Rowe, J. W., & Kahn, R. L. (1998). *Successful aging*. New York: Pantheon/Random House.

Schaal, M. D., Sephton, S. E., Thoreson, C., Koopman, C., & Spiegel, D. (1998, August). *Religious expression and immune competence in women with advanced cancer.* Paper presented at the American Psychological Association Conference, San Francisco, CA.

Smith, E. D., Merritt, S. L., & Patel, M. K. (1997). Church-based education: An outreach program for African Americans with hypertension. *Ethnicity & Health, 2*, 243–253.

The Joint Commission on the Accreditation of Healthcare Organizations in 1996. (2001). *2001 comprehensive accreditation manual for healthcare organizations: The official handbook*. Chicago: Joint Commission on the Accreditation of Healthcare Organizations.

Williams, D. R., Larson, D. B., Buckler, R. E., Heckmann, R. C., & Pyle, C. M. (1991). Religion and psychological distress in a community sample. *Social Science & Medicine, 32*, 1257–1262.

Woods, T. E., Antoni, M. H., Ironson, G. H., & Kling, D. W. (1999). Religiosity is associated with affective and immune status in symptomatic HIV-infected gay men. *Journal of Psychosomatic Research, 46*, 165–176.

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