Why Gerontologists Should Care About Empirical Research on Religion and Health: Transdisciplinary Perspectives

Linda K. George, PhD, 1 Warren A. Kinghorn, MD, ThD, 2 Harold G. Koenig, MD, 3,* Patricia Gammon, PhD, 4 and Dan G. Blazer, MD, PhD 5

1Department of Sociology, Duke University, Durham, North Carolina.
2Department of Psychiatry and Behavioral Sciences, Durham VA Medical Center, Duke University Medical Center, Durham, North Carolina.
3Department of Psychiatry and Behavioral Sciences and Department of Medicine, Duke University Medical Center, Durham, North Carolina and King Abdulaziz University, Jeddah, Saudi Arabia.
4Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, North Carolina.
5Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, North Carolina.

*Address correspondence to Harold G. Koenig, MD, Center for Spirituality, Theology and Health, Box 3400, Duke University Medical Center, Durham, NC 27710. E-mail: Harold.Koenig@duke.edu

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A large volume of empirical research has accumulated on the relationship between religion/spirituality (R/S) and health since the year 2000, much of it involving older adults. The purpose of this article is to discuss how this body of existing research findings has important messages or important new insights for gerontologists; clinicians in medicine, psychiatry, and psychology; sociologists; and theologians. In other words, what contributions do the research findings on R/S and health make to these disciplines? In this article, experts from each of the aforementioned disciplines discuss what contributions this research can make to their own area of study and expertise. Besides emphasizing the broad relevance of research on R/S and health to many clinical and academic audiences in gerontology (i.e., addressing the “so what” question), this discussion provides clues about where R/S research might focus on in the future.

Key Words: Aging, Religion, Spirituality, Health, Research, Transdisciplinary

More than 3,000 quantitative studies (at least one third involving older adults) have examined the relationship between religion/spirituality (R/S) and health, in addition to a vast number of qualitative studies. At least three-quarters of this research has accumulated during the past 20 years. The research has examined multiple health outcomes, including mental health, physical health, mortality, health behaviors, and faith community efforts at disease prevention. The research findings are summarized in two systematic reviews of original quantitative research on R/S and health published between 1872 and 2010 (Koenig, McCullough, & Larson, 2001; Koenig, King, & Carson, 2012a), as well as in two additional independent systematic reviews.
(Chida, Steptoe, & Powell, 2009; Powell, Shahabi, & Thoresen, 2003) and two meta-analyses (McCullough, Hoyt, Larson, Koenig, & Thoresen, 2000; Smith, McCullough, & Poll, 2003).

What are the implications for gerontological research and practice of this established corpus of research findings? How is this existing body of research relevant to gerontologists? Other than a brief but prophetic editorial by Krause (1997; and his voluminous original research), the writings of McFadden, Brennan, and Patrick (2003) and McFadden (2008), key original research by Idler and Kasl (1997a, b) and Idler, McLaughlin, and Kasl (2009), and a visionary recent theoretical review and research roadmap by Levin, Chatters, and Taylor (2011), there has been no comprehensive attempt to address this question for the past 20 years since publication of the seminal edited text, Religion in Aging and Health (Levin, 1993).

In the present essay, we focus not on summarizing the empirical R/S and health research itself or plotting a future research agenda but rather on how this rapidly growing body of recent research can inform gerontology and several disciplines relevant to gerontology: geriatric medicine, geriatric psychiatry/psychology, social gerontology, and theology. Our intent is to be inclusive so that our perspectives will be useful for both gerontologists per se and discipline-based researchers and clinicians who study and work with older adults. Research on the relationships between R/S and health has borrowed theories, measurement strategies, and analytic methods copiously from these disciplines. In return, we contend that R/S and health research also contributes to them in significant, but often overlooked, ways.

Contributions to Geriatric Medicine

For medicine, the critical issue is whether clinicians can use the findings from R/S and health research to improve the health of their patients. If this research has no value or potential for improving health, it has no relevance for geriatricians.

In fact, however, existing research strongly suggests that R/S is related to health, affects a wide range of health behaviors, and influences decisions on whether people seek health care and the type of medical care they seek. First, about three-quarters of the research on this topic indicate that certain R/S beliefs and behaviors help to maintain or enhance mental health (Koenig et al., 2012b, pp. 600–601). R/S beliefs provide meaning in life, purpose and direction that promote hope and optimism, and encourage forgiveness, gratitude, prosocial attitudes and altruism. These attitudes and behaviors generate positive emotions and help to neutralize negative emotions such as depression and anxiety. But not all R/S beliefs are beneficial to health. R/S beliefs that promote prejudice, discrimination, judgment or control of others, social isolation, or views of the Divine as punishing, merciless, and/or distant appear to have the opposite effect. Knowing this may assist in the development of educational or clinical interventions (at the individual or community level) to benefit mental health. Second, R/S beliefs and behaviors influence health behaviors and lifestyle choices. R/S beliefs and behaviors help to prevent or moderate several risky health behaviors, including cigarette smoking, excessive alcohol use, drug abuse, unhealthy eating, inactivity, and sexual promiscuity (Kvaavik, Batty, Ursin, Huxley, & Gale, 2010). It is important for health professionals to know this. Although they cannot prescribe R/S beliefs and behaviors, health professionals can ask about them (as they ask about other patient characteristics) to determine whether patients are at increased risk for disease (Murray & Lopez, 1996).

Third, certain R/S beliefs and practices may improve the ability of patients to cope with medical illness, whereas others may interfere with that ability. For example, praying or reading religious scriptures that give illness meaning and participating in a supportive faith community are behaviors that give the sick a sense of control, hope, and may reduce social isolation. The latter are known to positively affect disease outcomes and/or quality of life. Alternatively, negative religious coping—that is, beliefs that illness is a punishment from an unloving, vengeful deity; that one’s faith community has abandoned the person; or that the sole purpose of prayer is to cure the illness (frequently associated with disappointment and disillusionment when that does not happen [Blazer, Cohen, George, Koenig, & Verhey, 2011])—is correlated with worse mental and physical health outcomes. Negative religious coping generates spiritual distress that, if not addressed by trained health care chaplains or other religious counselors, may lead to depression or increase mortality (Pargament, Koenig, Tarakeshwar, & Hahn, 2001). Finally, this body of research has identified R/S beliefs (and influences by faith communities) that directly affect medical decisions—particularly end-of-life issues (e.g., whether to continue medically futile treatment
[Phelps et al., 2009]). Thus, research on R/S and health offers many practical and useful contributions to the practice of medicine and the health care field more generally and has the potential to help prevent illness, alter disease course, and improve the quality of care that health care.

**Contributions to Geriatric Psychiatry**

Empirical studies of religion and psychiatric disorders in later life can be examined through the lens of R/S and depression. The historical push in psychiatry to erect a barrier between psychiatry and religion (based on a reading and often misreading of Freud) has toppled due to at least three factors (Blazer, 2012; Kung, 1990).

First, the phenomenology of religious ideation and depressive symptoms lacks true boundaries (Blazer, 2011). Depression has been the most frequently studied psychiatric disorder in relation to R/S among the elderly adults largely because of their overlap in expression. For example, guilt associated with depression often is connected with religious beliefs, and apparent depressive symptoms (e.g., the “dark night of the soul”) are associated with religious experiences. Another factor contributing to the association of depression and R/S is loss of hope (Brown & Harris, 1978). The swelling prevalence of depression in Western society, coupled with rising rates of suicide, perhaps reflect increasingly dominant hopelessness.

Second, numerous empirical studies document the associations between R/S and depression. Depression is relatively easy to assess in clinical and community samples, typically with symptom checklists. Depression also is relatively prevalent; therefore, associations can be identified in samples of reasonable size.

Third, the preponderance of studies that show an inverse relationship between depression and religion/spirituality impel psychiatrists and psychologists to consider the salutary effects of a faith tradition and involvement in a faith community as part of the comprehensive management of the depressed. Though these studies are not definitive, the results suggest three conclusions: (a) individuals with no religious affiliation are at greater risk for depressive symptoms and disorders, (b) people involved in their faith communities may be at reduced risk for depression, and (c) private religious activities and beliefs are not strongly related to risk for depression.

Many questions remain unanswered and provide room for psychiatrists to further examine their working paradigms and practice. For example, depression is best expressed through narrative, yet the increasingly biological focus of psychiatry undermines the value of narrative in the diagnosis and management of late-life depression (Blazer, 1998; Krishnan, Hays, & Blazer, 1997). Depression necessitates a re-evaluation of one’s story, a retelling that incorporates emotional suffering that is very real but that may not be easily explained.

Religion/spirituality also has the potential to validate emotional suffering. The books of Job and Lamentations in the Hebrew Scriptures provide two excellent examples of individuals who symptomatically are profoundly depressed and have every reason to be so. Job is stripped of his possessions, his loved ones, and is afflicted with significant physical problems. No wonder he laments, “May the day of my birth perish, and the night it was said, ‘A boy is born’ [Job 3:3 [KJV, 1995]]. The writer of Lamentations bemoans the destruction of his beloved Jerusalem. “Is any suffering like my suffering that was inflicted on me, that the Lord brought on me in the day of his fierce anger?” (Lamentations 1:12 [NIV, 1984]). Job and Lamentations are so much embedded in Western culture that even secular and agnostic individuals know these texts and are quite likely to refer to them. The points made from these texts are not theological but relate to the human response to suffering.

In contrast, positive psychology, which has increased in influence over the past two decades, suggests that the natural state of Americans is that of a “positive people,” cheerful, optimistic, and upbeat. Barbara Ehrenreich confronts this premise head on in her book Bright-Sided: How Positive Thinking is Undermining America (Ehrenreich, 2009). “Thick” study and conversation between theologians/spiritual leaders and psychiatrists/psychologists should greatly enhance our understanding of the realities of the tough world in which we live, a world which has largely been glossed over by mental health professionals as they seek and expect the absence of depressive symptoms to be the new normal for our society. And these studies can help empirical investigators to refine their studies to better understand the association.

Perhaps the next step in the study of depression and R/S is to move beyond simple studies of association and prediction. What are the mechanisms,
both biological and psychological, that underlie the mounting evidence of an association between more frequent religious activity and increased levels of spirituality and lower depressive symptoms? How are the constructs of “depression” and “positive thinking” related and can positive thinking override depressive symptoms? To what extent does R/S encourage positive thinking (as opposed to, e.g., reflective thinking)?

Contributions to Psychology in Gerontology

Research on R/S challenges many of the reductionist assumptions about the nature of human beings put forth by early behaviorists in the field of psychology. Early theorists viewed people as products of external influences. Humans were the “Tabula Rasas” on which life experiences “wrote” and subsequently created inevitable behaviors. Missing from this conceptualization was the notion of free will and a soul. When facing the sometimes devastating and debilitating effects of serious illness, many individuals rely on religious coping. They join in the sufferings of the Hebrew people in Judaism or with Christ in Christianity and find enhanced meaning and transcendence in their suffering. Many identify with the prophets who endured challenging threats or with the Suffering Servant on the Cross and look for ways their suffering can benefit and even provide purpose in their capacity to better the lives of others. In fact, their suffering can be perceived as a way they themselves are made better, enhanced, and actualized.

The attitudes of those who rely on their faith in the midst of suffering can be startling. An example is a young woman, terminally ill with metastatic cancer, whose faith led her to the question, “Why not me?” instead of “Why me?” Her faith-based question led her to find meaning rather than despair in her circumstances and allowed her to minister to others more tormented by their plight. Her faith allowed her to rise above her circumstance, find meaning and purpose in it, and move forward in her support of others more frightened than she.

Research on R/S and health provides an answer for existential psychologists as well. Above all, R/S gives meaning to that which can appear meaningless, purpose to that which appears senseless, and transcendence to that which appears base or banal. And meaning is especially important in circumstances that appear incomprehensible. Research on R/S demonstrates positive ways that faith and prayer can lead one out of life and enhance living within life.

Among the evidence-based ways that R/S coping can assist in mental health disorders is the use of prayer in addressing anxiety and the physiological benefits prayer provides. Herbert Benson (1975) noted that his devout Catholic patients who regularly prayed “the Jesus prayer”: (Lord Jesus Christ, have mercy on me) could attain a state of parasympathetic de-arousal that was in sharp contrast to the “fight or flight” response of anxiety. Regular practice of this prayer—or any other meditative prayer or contemplation—can decrease overall arousal, which may result in less need for medications for chronic illnesses. Patients also experienced overall decreases in feelings of anxiety, along with an enhanced sense of well-being (Maltby, Lewis, & Day, 1999).

The capacity to face fears and stimuli evocative of anxiety also can be enhanced by religious coping. Faith in the presence of a divine beneficent being, accompanying one throughout whatever anxiety-provoking memory, thought, or experience lies ahead (or behind, in the case of Post Traumatic Stress Disorder), enables patients to more readily confront the troubling image, thought, or action they must perform. The support that scripture promises, of God’s profound presence in all trials and difficult circumstances, provides a level of courage for facing anxieties and fears. The biological basis of mental health disorders is now substantially documented. However, R/S research documents the ways the psychosocial environment can either help or hinder biologically based treatments. Negative religious coping styles heap blame on the afflicted individual to the extent that they are held responsible, or hold themselves responsible, for a moral or religious failure causing their distress. Positive religious coping can provide faith-based communities of support for the seriously mentally ill individual who often suffers isolation and rejection. Thus, the field of psychology has been immensely enriched by findings from R/S-health research.

Contributions to Sociology

The dominant issue in the sociology of religion for more than half a century has been secularization. Along with industrialization and urbanization, secularization is viewed as a key component of the transition from the premodern to the modern
What is secularization? In general terms, secularization is the transformation of societies from primary dependence on religious values, authority, and institutions to nonreligious—or secular—values, authority, and institutions (Sommerville, 1998; Taylor, 2007). Scholars differ substantially in beliefs about the extent to which secularization has penetrated modern societies. In part, this is because scholars differ in their assessments of the dimensions of secularization that have had the most profound effects on societies and their members. Three dimensions have received most attention. One dimension focuses on declining rates of participation in religious institutions and organizations as the critical feature of secularization (Schwadel, 2010; Sommerville, 1998). Rates of membership in religious organizations and regular participation in religious services declined gradually, but markedly over the 20th century in industrialized societies. In the United States, rates of public participation in religious institutions have fallen by 50% since 1900 (Taylor, 2007) although a large minority of Americans report attending religious services once a month or more (Chaves, 2011). In Europe, this trend has been even stronger. Several European nations report that 10% or less of the population affiliate with or attend religious services (Kauffmann, Goujon, & Skirbekk, 2012). By this standard, secularization is increasing in modern societies but is by no means complete.

A second dimension of secularization is the decline in the authority that religious institutions have over individual lives and societies more broadly (Chaves, 2011; Voye, 1999). Religious leaders are no longer viewed as the final authorities on either private attitudes and behaviors or public policies and regulations. Scholars emphasizing the decline in religious authority point to numerous examples in the United States including the prohibition of prayer in public schools and that Catholics are now as likely to use birth control and have abortions as non-Catholics. Chaves (2011) reports that although trust in public figures has declined generally in America during the past half century, loss of faith in religious leaders declined faster than faith in politicians and scientists, among others. Again, secularization is very much in evidence but remains incomplete.

The third dimension of secularization is the increasing privatization of religion in the modern world (Lambert, 1999; Regnerus & Smith, 1998). Scholars subscribing to this view argue that declines in participation in religious institutions are only part of the story and that commitment to religious values and practices remains strong in the nonpublic sphere. They note that the overwhelming majority of Americans believe in God or a higher power, pray frequently, and describe themselves as religious and/or spiritual. They also view the increasing proportions of people who describe themselves as spiritual rather than religious as a way that Americans distinguish between participation in religious institutions and a more private, individualized relationship with the sacred. This evidence suggests that declines in participation in organized religion should not be mistaken for abandonment of religious beliefs and faith. Secularization theory is unclear about whether nonorganization-based religious practices are a form of secularization. Even if they are, however, secularization is not complete.

Regardless of the dimensions of secularization to which scholars subscribe, all suggest that the power of organized religion as a social institution has declined over time. Indeed, some sociologists ask whether religious participation as analogous to joining a voluntary organization such as the Elks (Good, Willoughby, & Fritjers, 2009). How, then, does research on R/S and health contribute to our understanding of secularization? This research highlights the unique institutional character of organized religion.

Sociologists define social institutions as pervasive macrolevel forms of social structure that shape the lives of societal members. Two social institutions dominated the premodern world: religion and the family. Education, economic productivity, and the care of societal members were the responsibility of the family. Religion was the primary macrolevel institution, dictating the values, norms, and, often, political structures and policies of the society (Bruce, 1997). Medicine itself was based in religious institutions in the premodern world (Ziegler, 1999). Industrialization, urbanization, and secularization transformed the status and power of religion and family. Families were no longer the primary unit of economic productivity in industrialized societies. Specialized skills were required for industrial jobs, thus separating education from family functions. Urbanization separated family members from other kin. As industrialization spurred scientific discoveries and technological development, religion lost its stature as the ultimate source of truth and knowledge.
Unquestionably, the societal functions once allotted primarily to the family and religion underwent substantial reallocation. This does not mean, however, that family and religion lost all of their functions or their unique institutional capacities. Religion remains a viable, if less pervasive and powerful, institution. Research on the effects of R/S on health highlights the unique institutional character of religion. Religion uniquely fulfills three functions: social control, social support, and meaning. Research on R/S and health provides evidence of these functions.

Religious participants have better health habits than nonparticipants (Masters & Knestel, 2011; Mellor & Freeborn, 2011). Compared with nonparticipants, for example, persons who attend religious services regularly are less likely to smoke, to use illegal drugs, and to engage in promiscuous unprotected sex. This is evidence of the social control that public religious participation exerts on its adherents. In some denominations, health habits are explicitly prescribed and proscribed (e.g., Mormons, Jehovah’s Witnesses). Even denominations that do not have explicit rules regarding health habits, however, emphasize the gift of life and the responsibility of individuals to protect and nourish it (Black, 1999).

Other studies demonstrate the social support function of religious organizations. Most of us turn first to family and friends for social support during times of stress and challenge (Thoits, 1995). Research also documents that close, supportive relationships with congregational peers exert protective effects on health outcomes, even after support from other sources is taken into account (Krause, 2006). Conversely, however, strained relationships with congregational peers are a risk factor for poor health outcomes (Ellison, Zhang, Krause, & Marcum, 2009).

Another important function of religion is providing meaning for issues that strike at the very core of human well-being (Mattis, 2002; Shantall, 1999). Even science cannot explain why bad things happen to good people and good things happen to bad people. At one end of the continuum, the inability to find meaning in life’s tragedies and uncertainties can lead to existential despair. At the other end of the continuum is the ability to find meaning in life despite its injustices and the courage to find joy when possible and bear sorrow when one must. Of all the social institutions that structure our lives, only religion explicitly tries to generate the “peace of God which passeth all understanding” (Philippians 4:7 [KJV, 1995]).

Other social institutions do not provide the combination of social control, social support, and meaning that religion does. Can politics help us understand why innocent children sometimes suffer and die? Can the economy—or even science? Research on the effects of R/S on health generally supports the conclusion that attending religious services is the dimension of religious participation most strongly associated with better health (Ellison, Boardman, Williams, & Jackson, 2001; George, Ellison, & Larson, 2002). We do not yet know why this is so, but this pattern strongly suggests that something about communities of faith is especially beneficial for health and well-being. Sociologists should pay special attention to this finding because it suggests that participation in religion as an institution is more strongly related to health than private religious beliefs and practices. Thus, this pattern supports the assumption widely shared by sociologists that the effects of social organization are typically stronger than individual behaviors in shaping lives.

**Contributions to Theology and Religious Community Practices**

Gerontology rarely engages theology directly, and because theology frames the structures of meaning within which many older persons locate themselves, it is relevant to consider how empirical research in R/S and health can inform theology and the practices of religious communities. Many theologians have greeted the now-established empirical “religion and health” corpus, if at all, with a mixture of dismissiveness and suspicion. The first edition of the *Handbook of Religion and Health*, for example, was reviewed in few theological journals, and most reviews focused on its potential usefulness as a resource for chaplains and pastoral caregivers, not theologians. An analysis of “religion and health” research from a Christian theological perspective, cowritten by a theologian and a theologically trained psychiatrist with a long history in the research field, warns that contemporary cultural interest in the health benefits of religious practice reflects, at its worst, the individualistic, consumeristic, and therapeutic orientation of late-modern capitalist culture and is therefore not an expression but a “distortion” of faithful Christian practice (Shuman & Meador, 2003).
Theology arises within particular religious traditions, and the empirical R/S and health research will contribute to different traditions in different ways—but here, by way of example, and reflecting its continued influence within American culture, we consider ways that this research might contribute to Christian theology and practice (given that 91% of the U.S. population and 96% of those over age 70 with a religious affiliation claim this faith tradition (Pond, Smith, & Clement, 2010)). For Christian theologians, there is indeed much not to like about research on “religion and health,” and perhaps even more not to like about the numerous ways that it has been peddled to the broader culture. At its worst, research on religion and health can become a tool in the hands of those who wish to reduce religious practice to its instrumental or social value or who wish to package and commodify it. It can both reflect and shape the (unfortunate) individualistic and therapeutic culture of American Christianity. Many theologians grow weary of the dominance of the “sciences” in academic and intellectual culture, and to have “science” render judgment on the core of one’s own subject matter—God, and the creation as it relates to God—is interpreted by many as unwelcome and unacceptable intellectual colonialism. These objections should not be discounted lightly. We share many of them. But we argue here that research on the health implications of religious practice can and should usefully inform the work of Christian theologians. We will examine three reasons why this is the case.

First, research on religion and health can remind Christian theologians that religious practices are bodily practices. Christian theologians typically uphold the traditional Christian teaching that the human body, though wounded or scarred by sin, is created good and remains essentially good even in a fallen state. But this affirmation of the body’s goodness is not always accompanied by attention to the body’s role in the life of faith.

Second, religion and health research forces theologians to think critically about the ends of embodied human life and about the nature of embodied human flourishing. Many Christian theologians would blanch at the suggestion that religious belief and practice should be viewed as a tool for attaining better health. Although the assumption that faithfulness leads to better health has deep roots within American Christianity (Curtis, 2007), it does not comport well with Christian scriptures, which witness to a sinless and faithful leader who was tortured and executed (Jesus), to a early leader who learned to live with a “thorn in the flesh” (Paul), and to Jesus’ promise that those who followed him would suffer because of their commitments. Surely religion, then, is not about “health”—but then, having concluded this, theologians are forced to consider what is the telos of a faithful life? If the end of Christian practice is “salvation,” what exactly is this and what is its relationship to “health?” Indeed, what is “health?”—and why do the “health care” disciplines have such a difficult time defining “health,” the thing or state toward which they are supposedly striving? Such questions are not easily answered, but they are useful for the work of theology, and research on “religion and health” renders them unavoidable.

Third, empirical work on religion and health, if carefully done, can free theologians of idolatrous assumptions about the therapeutic goods of Christian belief and practice. As the Handbook of Religion and Health (Second edition) documents so carefully, religious practice and devotion is often, perhaps even usually, associated with improved social support, subjective well-being, and perceived health status, among many other outcomes (Koenig et al., 2012a). But this is not always the case. Negative religious coping, for example, in which a religious person feels abandoned or attacked by God, is associated with poor health outcomes, even though it is not incompatible with faithfulness (as the biblical lament tradition makes clear; Pargament et al., 2001). In another recent study, positive religious coping, in which one feels close to and supported by God, among terminally ill patients was associated with lower rates of living will completion and higher utilization of life-prolonging intensive care resources—outcomes that both health care professionals and theologians generally view as undesirable (Maciejewski et al., 2011). Such results are not only surprising nor subversive to the work of Christian theology but rather serve as reminders that religious belief and practice, even in its most faithful expression, is not always “health inducing.”

**Conclusion**

The purpose of this article was to demonstrate the relevance of research on R/S and health for several disciplines that are foundations for the gerontological enterprise. We sought to demonstrate that findings from this burgeoning, yet relatively narrow, field provide useful fodder for a
broad range of disciplines. For clinical disciplines, research on R/S and health has the potential to aid efforts to “treat the whole person” and to understand the foundations of health and well-being for older adults. For less-applied disciplines, sociology in this case, R/S and health research has the potential to challenge assumptions about modernity and reiterate the power of social institutions. And for some disciplines—as represented here by theology—research on R/S and health may contribute to both scholarship and some components of religious practice.

The authors of this article had extensive and stimulating conversations about disciplinary differences in evaluating—and even believing—the corpus of research on R/S and health and its implications for aging. In addition to the ways that R/S and health research contributes to specific disciplines, this article also is intended to demonstrate the need for understanding the perspectives of the wide range of disciplines that undergird gerontology. Social and behavioral scientists need to understand why theologians have reacted to this research with concern and even mild hostility. Scientists in this field need to understand why, in the absence of definitive causality, clinicians may believe it necessary to move cautiously and to incorporate the implications of research findings into medical practice in limited ways.

Although younger generations are not as religious now and help to explain the secularization trends in both churches and the academic disciplines, the importance of R/S in the lives of older adults in the United States is evident. Gallup Poll data indicate that 72% of persons age 65 or older report that religion is very important to them compared with only 47% of those aged 18–29 (Newport, 2006). This pattern (older adults being more religious than younger adults) has been a constant since the early 1940s when the American Institute of Public Opinion first began polling (Erskine, 1965). Furthermore, persons over age 65 are more likely to be involved in religious organizations than in all other social organizations combined, and not surprisingly, religious congregations are the most common source of social support for older adults outside of immediate family members (Cutler, 1976; Koenig, Moberg, & Kvale, 1988; Krause, 2008; Payne, Payne, & Reddy, 1972). If this is true, then all disciplines in gerontology that care and address the concerns of older adults have a stake in research that examines the links between religious involvement and health. Our hope is that the range of perspectives presented in this article will stimulate additional conversation on the topic.

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