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Interview with Dr. Ellen Idler

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Editors' Note: We are pleased to present the fourth in PHRS Bulletin's series of featured interviews with influential contributors who have shaped the field of public health, religion, and spirituality.

We present an interview with **Ellen Idler, PhD**, Director of the Religion and Public Health Collaborative, and Professor in the Departments of Sociology and Epidemiology at Emory University. Dr. Idler was interviewed for the *PHRS Bulletin* by graduate students Lena Musoka and Angela-Maithy Nguyen of U.C. Berkeley, working in conjunction with Angela Monahan, an ASPPH/CDC fellow at the Department of Human and Health Services.

Angela-Maithy Nguyen: For your 1985 doctorate in sociology at Yale, your dissertation was titled "*Cohesiveness and Coherence, Religion, and the Health of the Elderly*"; at that time, there were very few scientific publications focused on religion, spirituality, and health. How did you become involved in this field and what was it like for you to work in this research area at that time?

Ellen Idler: I'm a preacher's kid; I guess you could say I was always somewhat familiar with and interested in religion because I, more or less, grew up in a church. My father was a Presbyterian pastor, and was a very progressive social justice activist involved in civil rights and protests against the Vietnam War. That was the kind of household that I grew up in. I went to a Presbyterian college and the year after graduating, I got a Rockefeller Brothers Fellowship and studied for one year at Union Theological Seminary. Although I don't have a Master's of Divinity, I did all the first-year coursework for an M.Div. and decided that wasn't really for me. It was a very important institution; Union Theological Seminary is just a treasure.

Then, I went to Rutgers for a year. I worked on a project with Peter Berger, who was a very well-known sociologist from the mid-to-late 20th century. I worked on a project on health, one of several on a larger project on "mediating structures". Religion is one of the mid-level social institutions that people have a voice in and bring agency to individuals, but at a scale that allows them to have ownership and authority within it because it's facing both ways. Religious groups, for example, face their congregation members but they also have a public and community presence that's important. They have an upward-facing, as well as a downward-facing presence. It was a policy project, I was on the health panel. Because of my background in sociology, I did think a lot about Émile Durkheim and the power of social institutions, the strong overlap between religion and society, and how you can't consider one without understanding the other. I started developing some ideas about how if religious groups protect people against suicide, maybe suicide is not the only health outcome you could look at. I was jumping off of Durkheim to get some ideas about society, especially in the form of religious groups and their protective effects on health.

Ellen Idler

I started graduate school in 1979, the same year that Lisa Berkman and Leonard Syme published the landmark paper on social networks and mortality. Their findings were that social ties were just as important as whether you smoked or got enough sleep or not, in terms of health outcomes. I was very privileged that I was starting as a graduate student while Lisa Berkman was a faculty member. She began the Yale Health and Aging Project, and I was able to use the data from that large community study. I should also mention the very important role of Stan Kasl, with whom I co-authored a number of papers. He was a professor at Yale and a member of the faculty group working on the Yale Health and Aging Project. It was because of him that there were five questions about religion in the Yale version of those studies. I was really fortunate that the topic I wanted to study was being included in the survey. Sociology of religion is a big thing in sociology, right? Sociology of health and medicine is another, but nobody had really put them together. Although I felt like I was kind of on my own figuring it out, I didn't have any opposition from the department. I had good mentors. They were letting me do my thing.

If anybody wants to go into this field, there's a lot to draw on.

– Ellen Idler

Lena Musoka: Since your dissertation, how have you seen the field of religion, spirituality, and health change?

Ellen Idler: Well, there's a lot of research in that area now that wasn't there before. I've been working on a big project doing systematic reviews of different literature on religion and health, and there's a vast number of people engaged in studies of every different kind of health outcome. The early studies didn't have many religion variables to study; if there was anything, they had religious attendance. I'm a sociologist, so religious social participation is the most important part of it to me, but there has been a huge amount of work put into measuring the different dimensions of religion. I think many people in psychology want to have a scale so they can reduce error, but if you have a very multidimensional phenomenon, creating a scale that is measuring a whole bunch of different dimensions and adding them up together isn't going to help you at all – especially when some of the dimensions of religion are associated with worse health outcomes and others are associated with better health outcomes. If you add them together, you'll get absolutely nothing. Today there's a lot more sophistication in terms of measurement of religion and of the wide variety of health outcomes that are available, not only physical and mental health but also health behaviors and practices. There's a very large body of good research now. If anybody wants to go into this field, there's a lot to draw on.

Angela Monahan: Was spirituality always a part of the field, or did it gradually expand from religion and health to spirituality and health?

Ellen Idler: That's a big subject. No, the early studies didn't have measures of spirituality. For example, if you go back to the Alameda County Study, the measure that they had was of social ties because all they were trying to do was have religious group membership be one type of social tie in a social network index. They didn't particularly care about people's interior life and didn't even know if they were Protestant, Catholic, Jewish, other, or none. Most of the time, researchers didn't really know anything about the communities they were studying people

in. Some studies were of just one religious group's health compared with the general population, so they weren't representative at all. Spirituality was not being asked about by any of these earlier studies. Coming from studying older populations, as I did with the Yale Health and Aging Project, if you ask older people 'how religious are you?' and then ask them 'how spiritual are you?', they will just look at you like you're crazy and ask why you are asking them the same question. The two concepts are not different for many people, so there's complete overlap. I think including a spirituality question is a good and really important thing, but it doesn't have anywhere near the power to explain health outcomes that religious attendance does. It's really the variable about social contact and membership in a community group that makes the difference for health, certainly for the strongest outcome of all-cause mortality. The other more subjective measures about intrinsic religiosity, how often people pray, private practices, and self-identity characterizations don't have the same health effects.

Angela Monahan: Speaking about measures, you were involved in a working group assembled by the Fetzer Institute and National Institute of Aging for the book that was prepared on measures of religion and spirituality. What was that experience like?

Ellen Idler: The Fetzer Institute called together some really good people who wanted to improve the measurement of religion to figure out what the "active ingredient" was. Fetzer gave money so that we could have a module in the General Social Survey (GSS) in 1998. The GSS allows people to buy time on the survey. Normally, you would field a lot of items to get data to analyze, and you would make scales and look at your alphas to decide what the really good measures were – but there were limited funds, so we had to come up with a brief version of the measures. I'd say the most valuable product of that group would be the article that was in *Research on Aging* that analyzed the data.

It was our very good luck that Mark Chaves at Duke University fielded the National Congregation Study that same year, in 1998, within the GSS. There were tons of questions on religion. They did hyper-network sampling. If people said that they were a member of a congregation, they would ask what congregations they were members of. The initial sample was probabilistic – it was a randomly selected representative sample of the US population. Through those individuals, they got the identities of congregations, and then they went and asked questions to people at the congregations that were identified. There've been three follow-ups since.

In any case, we landed in the 1998 GSS, and it was a good way to see what some of those different dimensions were, but there's always a whole lot of competition for space on any survey. We're mostly talking about surveys because public health and sociology mostly do that. Every survey is a huge investment, and if you really want good health measures, that takes a lot of time in a survey. So, you can see why something like religion isn't going to be able to get more than just a very small amount of time on any health survey. As I said, attendance is the most common item, but it's a really good one. If you're putting your survey together, just be sure you put attendance in, and religious affiliation as well because it gives you some idea about the representativeness of the sample. However, it's really better to have population-representative samples, which will have religious diversity in them.

Angela-Maithy Nguyen: In 2009, you moved from Rutgers University to Emory University, becoming Director of the Religion and Public Health Collaborative. How did the opportunity arise for you?

Ellen Idler: Well, it was a wonderful opportunity. In 2006, Emory University received a very large gift from two researchers who had discovered one of the most important drugs for HIV/AIDS. They turned the patent over to the university, which meant that gazillions of dollars came to the

university. They built some buildings with it, but they also had proposals for 'strategic initiatives' that had to be interdisciplinary for which faculty members across the university could put in proposals. One of the proposals was for the Religion and Public Health Collaborative, which was successful because there was such a strong history coming at Emory prior to that; but also from the Carter Center before that. Back in 1989, William Foege, one of the gods of public health, was the director of the Carter Center. He and President Carter organized an interfaith conference on religion and health called the Church's Challenge in Health. The Atlanta Interfaith Health grew out of that, and then it became the Interfaith Health Program. The Interfaith Health Program stayed at the Carter Center until 2000. They did a lot of community projects, especially on vaccination and other drives that could be organized with faith groups.

In 2000, the program moved over to the Rollins School of Public Health so that they could expand. Then the opportunity for the strategic initiative came along and a group of faculty, including Carol Hogue, Mimi Kiser, John Blevins, Karen Scheib, Emmanuel Lartey, George Grant, and others put their heads together and said, 'well, we could propose a dual degree program between Candler School of Theology and the Rollins School of Public Health, we could get a certificate, could have faculty members teaching all these new courses, and we could hire somebody' – and they hired me. I so admired the institution and the approach of the Interfaith Health Program because, to me, it took my thinking about religion and health to a whole other level of not just considering only individual health outcomes, which was all I ever thought about. Yet, here was a group that was thinking about what organizations do to promote public health. People in public health really like to organize, and guess what? That's what people in religion do, too. They are so good at organizing things.

The idea is that very important things can happen from organization to organization, but public health and religion don't necessarily always get along very well, trust each other, or know how to work together. That's always a problem in HIV and women's reproductive health; those have been areas of contention and conflict. Religion has a bad name in public health.[4] Sometimes public health researchers work in religious communities, take advantage of them, and don't ever give anything back – they just use people. There is a lot of mistrust on both sides, understandably. It seemed as if an opportunity for educating students to work on both sides was needed. Some students get Candler degrees and some get public health degrees, but the idea was for them to be in classes together. In my class, there are Rollins MPH students from global health or epidemiology, and then there are Candler students and Sociology students. They get to understand each other's training and preparation for their leadership roles. Rollins is a premier school of public health, and Candler is a premier school of theology – these people are going to be leaders in their careers. The idea of promoting the openness that leaders can have to work with others outside of their own sector is the kind of thing that I hope we're investing in to get there. They are students now, but they're going to be leaders; I just know they are – they're fantastic people. I think that having an understanding or some kind of common language and learning how to build bridges is going to be a really important thing for public health.

Angela-Maithy Nguyen: We like to hear that, and I liked that you mentioned the bridge. We need to have more of that bridging across students and across different programs.

Ellen Idler: Every year, we have a graduation ceremony for students getting their certificates[5] and dual degrees. Emmanuel Lartey [a faculty member at Candler], who is Ghanaian, has somebody who makes these stoles for him. They're made of Kente cloth and say "*Religion and Health at Emory*" on them. They're so cool and outrageously great. Every year I make a few remarks and say, "we hope that you're going to go forth to be master bridge builders because the bridges are so important." It's a great metaphor for

Emory because Emory has this huge bridge that goes over the railroad tracks that run right through the center of campus and separates the health sciences from the college and law school. People walk across that bridge all day long; I have crossed it many times. The bridge builder is a kind of natural Emory metaphor for that, but we also hope our students become faithful translators. I think the translating of language from public health to religion and back again is really important for people to be able to faithfully and honestly understand the context of why people say things the way they do and to be able to explain to others who maybe don't. I think that's really important.

Angela-Maithy Nguyen: Can you briefly share information about some of the current or ongoing projects that the Religion and Public Health Collaborative are currently supporting?

Ellen Idler: We just did a really neat paper on religious responses to COVID-19 using quantitative computational text analysis of New York Times articles that mentioned religion in the first six months. We compared that with the guidelines from the World Health Organization and the CDC for faith communities and with the statements or guidance that was provided on the websites of religious groups. It was really fascinating. Sentiment analysis has a dictionary of terms of value. You can analyze massive amounts of text using it. I had two smart graduate students helping me do this – it was really fun. So, I hope that's going to come out soon. I have been writing some other papers about secularization and religion and health research, which I think is also a pretty important topic.

Lena Musoka: In 2014, you published a book that you titled "*Religion as a Social Determinant of Public Health*." What was that experience like? Why did you title the book "*…determinant of public health*" rather than simply "*…determinant of health*"?

Ellen Idler: That's a good question. 'Social determinants' had to be in the title, we really wanted to address it to a public health audience – in fact, many of the authors are from the School of Public Health. The first year I got to Emory, we had a once-a-month faculty meeting where different people would share what they were working on. That was fun, but we were just talking to each other. So I thought, "We have all these great people here. Why don't we do a book?". Usually, when you have an edited volume, it comes from a conference or someplace where you invite people to send papers, so there isn't any growth or development of the papers in the context of each other. I had a fully formed vision of what the book should look like, but we had to get people signed up to write the chapters. People were so nice – they didn't even know me, I was new, but they agreed to it. For example, Abdullahi An-Na'im, who is from Sudan, is one of the world's experts on Islamic law and a professor at the law school. We were doing these short religious practice chapters and we wanted people who had a deep knowledge of those religious practices. Somebody suggested I should be in touch with him to get him to write a brief chapter about Ramadan fasting. People study the health effects of Ramadan fasting, and billions of people all over the world are doing it, so it qualifies as a religious practice that could have big population health effects. We had coffee and I said we'd like you to just write about the lived experience – the concrete bodily experience of Ramadan. He wrote this beautiful chapter about when he was an adolescent. It's a very big thing for people to decide that this is going to be their first Ramadan, that they're going to fast for the first time. 14 to 15-year-olds have to make a decision if they're going to try, or if they're going to declare that they're doing it. It's really hard, and I had never thought about it before.

Lena Musoka: That is great. We know that Emory's Religion and Public Health Program has international ties, especially with various African countries. Could you tell us how you've been involved with Emory's international project and specifically your work with African countries? How was your experience navigating the religion and spirituality fields in regions like Africa,

where culture and religions are deeply intertwined?

Ellen Idler: Well, that's a great question that I don't really know the answer to! I have never been to Africa. I have not had much to do with those programs, but the Interfaith Health Program absolutely has and they have had the President's Emergency Plan For AIDS Relief (PEPFAR) contracts and worked very extensively with the church health organizations of a number of African States. John Blevins has been principal investigator on the PEPFAR grants and most of the time, he works on a Gates Foundation project called the Child Health and Mortality Prevention Surveillance (CHAMPS), to reduce mortality of children under five. They have projects in Africa and Asia, and they want to do autopsies on infants and young children for this project to better understand the causes of mortality. You can imagine how difficult getting the agreement of parents is. Understanding the cultural and religious context of the parents and having trainers and people who work for the study that can speak about all of these significant issues is really important.

Angela Monahan: Is Emory's attention to religion, spirituality, and health part of a larger set of initiatives to address the importance of religion in American life and in the larger world?

Ellen Idler: Yes, I would definitely say that it is. The Candler School of Theology has a very big emphasis on public theology now and have Theo Ed Talks, the equivalent of TED Talks. They're also applying for a Lilly Endowment grant now too. There's not necessarily a health dimension to some of it, but in terms of public scholarship – yes. I think because of the proximity of things on the campus, you can walk from any part of Emory to any other part of Emory. You can walk to the Centers for Disease Control and Prevention (CDC) – it's right across the street. There's more likelihood of people getting to know each other across the schools than there is at another university where they are far apart from each other; not walkable at all and people don't know each other. The faculty of Emory's Department of Religion and the faculty from Candler form this giant Graduate Division of Religion. I would say that the study of religion is taken enormously seriously – the Dalai Lama is a faculty member for instance. World religions are a very important thing, besides the professional school, for preparing people for the ministry. I had come from a state university and noticed a big difference. I also came from the North, from a very secular New Jersey with its state university that had hardly any religion department at all, to Emory where there were all these leading scholars of religion and culture. Being in the South, there's a whole lot more religiosity than there is in New Jersey – it was definitely different. I felt like it was a much bigger intellectual space because people could talk about religion, without it being stigmatized, as it often is in our secular universities.

Angela Monahan: The field of religion, spirituality, and public health partly overlaps with medicine and clinical psychology. There is a whole list of fields concerned with the clinical implications of religion and spirituality, but what do you see as the most important and distinctive questions addressed in the field of religion, spirituality, and public health?

Ellen Idler: We do work closely with people in the School of Medicine, and George Grant, the Director of Spiritual Health for Emory Healthcare is a member of the RPHC executive committee. He just organized a really great webinar called Sacred Work. I was one of the speakers with Emmanuel Lartey, a faculty member from Candler, and we were speaking from the religious side about the kind of sacred work that people do in public health and medicine and what individuals and organizations are able to accomplish. The chaplaincy service at Emory comes under George Grant's purview. We've done some research with the chaplains. I also work closely with Emory's Palliative Care Center. There is a clinical facing part of what we do. The provision of health services for people in the community is public health. Health systems

have an important role, and need to make a place for the religion and spirituality of patients.

Angela Monahan: Religion and spirituality can be a part of any field really, it's very broad. That was all of our questions – you've given us a lot of good information and stories!

Angela-Maithy Nguyen: Thank you for being very open and for sharing your thoughts and experiences with us. We really appreciate it, and I think our readers will appreciate this interview as well.

Ellen Idler: You're very welcome. It was certainly my pleasure. Good luck to everybody.

This interview with Dr. Ellen Idler took place over Zoom on April 9, 2021. The transcript has been edited for clarity and brevity.

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[4]^See article by Christina Gebel (this issue: http://www.publichealthrs.org/a023/) for an account of recent experiences of the reputation of religion in public health.

[5]^See Dr. Idler's article in the first issue of this *Bulletin* about the 2019 Emory commencement ceremony for religion and public health graduates (Idler, 2019, http://www.publichealthrs.org/a002/).