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This is the first annual bundled issue released by the *PHRS Bulletin* – for more details please see Editors' Introduction: Fall 2021 Issue #5, this volume, page 16 (or online).

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Editors' Introduction: Spring/Summer 2021 Issue #4

Welcome to the fourth issue of the *Public Health, Religion and Spirituality Bulletin (PHRS Bulletin)*, published by the Public Health Religion and Spirituality Network (PHRS Network).

This issue is short but sweet. It begins with an interview with Ellen Idler, Director of the Religion and Public Health Collaborative at Emory University, where she is also Professor in the Departments of Sociology and Epidemiology. She describes what led her into the field of religion/spirituality and public health, and how Emory became a nationwide leader in this field, offering more coursework and programs than perhaps any other university in North America. Next is an article authored by early career professional Christina Gebel, who describes how she has brought together her passion for public health and her religious identity. This issue closes with our updated resource article highlighting new empirical work, upcoming conferences, recent conference proceedings, and COVID-19 related resources.

The last time we released an issue in November 2020, the world was well into the COVID-19 pandemic and uncertainty was abundant. Happily, through heroically accelerated yet effective vaccine development and dissemination, and many other public health preventative measures, the United States is thankfully in a different position than we were only 8 months ago. Much of the country is cautiously reopening and attuning itself to a 'new normal' – yet we are aware that internationally, many challenges remain, including shortages of vaccines in many countries. We hope that our readers everywhere are healthy and as safe as possible, and that all of us working together – faith-based organizations, health professionals, and the general public everywhere – can soon bring widespread safe reopening to large and small communities everywhere.

We wish to thank you for being a crucial part of the PHRS network. These bulletins would not be possible without you! As 2021 continues on, we urge all our readers to enjoy the northern hemisphere summer months and, if able to do so, to receive their vaccinations or find trusted and evidence-based resources to learn more if desired.

Sincerely,
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Interview with Dr. Ellen Idler

Angela-Maithy Nguyen,[1] Lena Musoka,[2] and Angela Monahan[3]

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.

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.

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

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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[1]^Angela-Maithy Nguyen, MPH, is a third-year doctoral candidate in the School of Public Health and was a 2020-2021 trainee in Public Health, Religion, and Spirituality Traineeship at the University of California-Berkeley (angela_nguyen@berkeley.edu).

[2]^Lena Musoka, MPH, is a recent graduate of the master's program in the School of Public Health and the Public Health, Religion, and Spirituality Traineeship at the University of California, Berkeley (lenamusoka@gmail.com).

[3]^Angela Monahan, MPH, is an ASPPH/CDC fellow at the Department of Human and Health Services, and a graduate from the Infectious Diseases and Vaccinology master's program and the Public Health, Religion, and Spirituality Traineeship at the University of California Berkeley (angela.grace.monahan@gmail.com).

[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/).

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Showing Up as My Whole Self: Finding a Way to Marry My Public Health Career with My Religious Identity

Christina Gebel[1]

Editors' Note: The PHRS Bulletin *regularly features accounts and reflections from early career professionals in public health about their discovery, training, knowledge, work, and reflections upon spiritual and religious factors in public health.*

I grew up in a very homogeneous environment: the mostly White suburbs of Cincinnati, Ohio where all the kids went to either the public school or one of the dozens of Catholic parish schools, scattered about the city and beyond. I went the way of many of my childhood peers: Catholic same-sex high school, then Catholic university, and all within a farther, yet similar, radius of living in Midwest cities along the way. It would be fair to say that I was the fish, and I never really noticed the water I swam in.

Christina Gebel

One of the experiences that changed all of that was attending Boston University School of Public Health for my MPH, my first time attending a school that did not have a Catholic affiliation and living in a city in a quite different part of the country. Boston and graduate school wooed me from the beginning: I had never lived so close to the coast and Boston seemed to have limitless brilliant people simply going about their lives and doing groundbreaking things in their respective fields. The water was entirely different, and the tank was much, much bigger.

As I went through my degree and eventually my public health career, I felt a subtle yet tangible piece of me missing: my identity as a Catholic; an identity I had nurtured since childhood, and had eventually led me as an undergrad at Saint Louis University to study theology. While the East Coast setting stretched my brain in so many ways, I found myself shutting off my theology brain in order to better fit into a field that sometimes made religion – and, as I felt most personally, Catholicism – the butt of jokes around a meeting table. Religion was seemingly viewed as little more than the opponent in a battle for reproductive access and rights.

When I was about to resign myself to the fact that I would never come to the field as my whole self, a public health practitioner and a lifelong Catholic, a few instances of hope found me. The first was when a professor of mine, who taught a course on reproductive advocacy, asked if I could summarize the Catholic viewpoint on abortion so the students could understand it or at least, in my mind, dispel some myths. I was struck that anyone would even ask to understand it, and I readily agreed, though asked that it be distributed without a by line. It was the hardest piece I wrote during graduate school, not because it was even for a grade but because it meant the most to me personally. Not long after the professor assigned it for class, the teaching assistant, a friend of mine, came to me and said a paraphrase of the following, "I know you wrote the reading we assigned in class. While I don't agree with you [on abortion], I learned a lot, and I understand where you're coming from."

The second opportunity came when our Dean asked if I could be a discussant of a talk about Spirituality and Health, a live-streamed, recorded, and school-wide event. Again, I poured myself

into my presentation, weaving between my academic brain and my deeply held beliefs. To be in front of the room and speak openly about my Catholic faith to my public health colleagues, not only signaled to me progress in this often fraught intersection but also it simply felt different. I was my whole self that day; the fish, I realized, could swim anywhere.

Today, I bring my whole self to my work in the field of Maternal and Child Health. While I still experience much of the same things that make me cringe quietly among a group of colleagues, I've also pushed myself to find other religious colleagues in my field and to speak openly about religious identity being an often overlooked, yet essential, part of building trust in communities and working towards diversity and inclusion. My goal is to eventually launch a brand where I can combine my public health knowledge on pregnancy with a formation series for expectant Catholic families so that people can find an environment that views childbearing as not simply a clinical experience, but a deeply spiritual one as well.

"There aren't many of us, but we're there," I often say when I find another public health colleague, young in her career, who feels she can share her religious identity with me. The fish swims in a school, and I hope I can help others to realize that.

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[1]^Christina Gebel, MPH, co-founder of Accompany Doula Care; birth doula and childhood educator; maternal and child health public health professional (cgebel@gmail.com).

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Resources & Updates: Spring/Summer 2021

PHRS Staff

Editors' Note: This section emphasizes resources at the intersection of religion/spirituality and public health, as well as major organizations that at times address these intersections. Please see the "Resources" tab on the PHRS website for more content, and please send new potential content to this section to: PHRSadm1@publichealthrs.org and phrsadmin0@publichealthrs.org

COVID-19, Religion, and Public Health

- May 2021 Webinar: The role & impact of faith actors in global and national advocacy for vaccine equity and access
- May 2021: "If a rabbi did say 'you have to vaccinate,' we wouldn't": unveiling the secular logics of religious exemption and opposition to vaccination (Kasstan), *Social Science & Medicine*
- May 2021: Faith-based Approaches Can Overturn Vaccine Hesitancy (Hornbeck)
- March 2021: Faith leaders' year of pandemic: grief, solace, resilience (Henao, Crary, and Fam)
- March 2021 Webinar: Vaccines, the Role of Faith Groups, and How to Stay Safe
- March 2021 Podcast: Religion in the Time of Pandemic
- March 2021 Webinar: Partnerships in Religion and Public Health: Lessons Learned for the COVID-19 Pandemic
- March 2021: Combating Contagion and Injustice: The Shared Work for Public Health and Faith Communities During COVID-19 (Williams, Miller, and Nussbaum), *Journal of Religion and Health*
- January 2021: Churches in predominantly Black communities can play a key role in vaccinating against COVID-19 (MacDonald)
- January 2021: More Americans Than People in Other Advanced Economies Say COVID-19 Has Strengthened Religious Faith (Pew Research Center)
- January 2021: Taking the Cloth: How Religious Appeals Increase Compliance with COVID-19 Prevention Measures (Adida et al.), *SocArXiv Papers*

New Research & Materials

- May 2021: Religious Service Attendance and Implications for Clinical Care, Community Participation and Public Health (VanderWeele, Balboni, and Koh), *American Journal of Epidemiology*
- May 2021: Religion, Aging, and Public Health (Levin and Idler), *Oxford Research Encyclopedia of Global Public Health*
- April 2021: Measuring Well-Being: Interdisciplinary Perspectives from the Social Sciences and the Humanities (Lee, Kubzansky, and VanderWeele), *Oxford University Press*
- April 2021: Religion and the World Health Organization: an evolving relationship (Winiger and Peng-Keller), *BMJ Global Health*
- February 2021: Training to Conduct Research on Religion, Spirituality and Health: A Commentary (Koenig, Hamilton, and Doolittle), *Journal of Religion and Health*
- February 2021: [CHAPTER] Religion, Spirituality, Belief Systems and Suicide (Teo, Duchonova, Kariman, and Ng), *Suicide by Self-Immolation*
- February 2021: The Study on Stress, Spirituality, and Health (SSSH): Psychometric Evaluation and Initial Validation of the SSSH Baseline Spirituality Survey (Warner et al.), *Religions*
- January 2021: Religious Beliefs About Health and the Body and their Association with Subjective Health (Walters and Benjamins), *Journal of Religion and Health*
- December 2020: Religion and Spirituality among American Indian, South Asian, Black, Hispanic/Latina, and White Women in the

Study on Stress, Spirituality, and Health (Kent et al.), *Journal for the Scientific Study of Religion*

Articles, Commentaries, Interviews, Webinars

- TheoEd Talks from Emory University (ongoing)
- Emory Spiritual Health Youtube Playlist (ongoing)
- Duke University Center for Spirituality, Theology and Health: Spirituality, Theology and Health Seminars (ongoing)
- Religion, Spirituality and Health Scientific Interest Group: Development of an Instrument to Assess Psychosocial Spiritual Healing – The NIH HEALS, Recorded Webinar from May 18, 2021
- Religion and Mental Health: Is the Relationship Causal?, Recorded Seminar from April 27, 2021
- Sacred Work: Science, Religion and Human Health with Ellen Idler and Rev. Emmanuel Lartey, Recorded Webinar from March 31, 2021
- Religion, Spirituality and Health Scientific Interest Group: Harmonizing the Spiritual and Scientific Worldviews, Recorded Webinar from February 9, 2021
- The International Association for Spiritual Care Seminar Series "What Is Spiritual Care from the Perspectives of Our Different Professions?" (Includes seminars on Medicine, Public Health, Psychology, Nursing, and Pastoral Care), Recorded Seminar Series (Jan 5 to Feb 2, 2021)
- Decolonizing Global Health Series | "The Role of Religion & Culture in Shaping Global Health", Recorded Webinar from January 19, 2021
- Bridging the Gap Between Science and Faith, Recorded Webinar from December 14, 2020

Upcoming Conferences & Conference Minutes

- UPCOMING: International Research Network for the Study of Science & Belief in Society (INSBS 2021 conference): STEMM and Belief in Diverse Contexts: Publics, Praxis, Policy and Pluralism; Online conference 7-9 July 2021 (FREE REGISTRATION): https://scienceandbeliefinsociety.org/2021/05/24/open-for-registration-insbs-conference/
- UPCOMING COURSE: Duke University Center for Spirituality, Theology, and Health's 17th Annual Course on Religion, Spirituality and Health, August 9-13, 2021: https://spiritualityandhealth.duke.edu/index.php/5-day-summer-research-course
    - Partial Tuition Reduction Scholarship Application – Link
    - Full Tuition Reduction Scholarship Application for those in developing countries – Link
- UPCOMING: Health Ministries Association National Conference: One Voice, One Vision: Wisdom for Healthier Communities; The 2021 HMA National Conference will be held virtually over 3 weeks in October, with a session offered 2 days each week, Tuesday/Thursday: October 5 & 7, 12 & 14, 19 & 21, 2021). Further details at: https://hmassoc.org/news-events/upcoming-conference/
- PAST: Spirituality in Research, Professional Practice, and Education – The Sixth International Conference of the International Network for the Study of Spirituality, June 7-8, 2021: https://spiritualitystudiesnetwork.org/Conference-2021/
- PAST: Caucus on Public Health & Faith Community (CPHFC) and APHA's Virtual Networking and Fellowship Event – Faith & Public Health: Allies & Partners in Disease Prevention and Health Promotion, March 14, 2021: https://www.rphcemory.org/event/faith-public-health-allies-partners-in-disease-prevention-and-health-promotion/

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Bulletin Information

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Editors' Introduction: Fall 2021 Issue #5

We are pleased to share with you the fifth issue of the PHRS Bulletin. In our ongoing aim to use your time carefully, we are now producing shorter issues that we expect will always feature an interview with a leading PHRS scholar, at least one substantive article, and updated resources and announcements as there are many ongoing and exciting advancements in the field. Going forward, we will re-bundle the spring and fall issues of the Bulletin into an "annual issue" to allow another opportunity to engage with PHRS content. We have also updated our website to display all of our past articles in a way that is more accessible if, for example, you want to read more from our interview series, or find a piece written by a scholar you admire, or learn about the integration of religion, spirituality, and public health from of an early career professional. Here are some clickable links:

- Download a PDF of the new full Issue 5
- View All Articles by Type
- View All Articles by Date

As always, we hope this note finds you and your loved ones healthy and well. Happy reading!

Warmly,

The PHRS Editorial Team
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NIH and NIMH Research and Strategic Planning Must Address Religion and Spirituality

Doug Oman,[1] David H. Rosmarin,[2] and Brandon Vaidyanathan[3]

The PHRS Bulletin publishes a wide range of articles, including advocacy-focused articles that may alert readers to opportunities to support expanded funding, empirical study, or educational initiatives at the intersections of religion, spirituality, and public health. In this piece, Oman, Rosmarin, and Vaidyanathan describe their recent advocacy for the inclusion of religion and spirituality within the strategic plan at the National Institute of Mental Health. The appendices in particular offer a window into what this sort of advocacy looks like in practice along with compelling statistics about the relative lack of attention to religion and spirituality within the National Institutes of Health.

It seems amazing that in 2021 the strategic plans of the National Institutes of Health (NIH) and National Institutes of Mental Health (NIMH) still hardly recognize the relevance of religion and spirituality to health, allowing far too much ongoing federal-funded research to remain oblivious to religious/spiritual (R/S) influences. Such outdated underfunding arguably contributes to many unfavorable outcomes, ranging from poorer clinical care to poorer governmental and health-system responses to the current coronavirus pandemic.

Yet change can happen, and will happen, if those of us who are knowledgeable and concerned put in the needed effort. Small individual efforts can help (see below). Of course, overnight updates are not possible to how the NIH and NIMH approach religious/spiritual factors, because these are enormous organizations with many established procedures. Perhaps progress will only come through sustained and savvy lobbying by organized networks of citizens and health professionals who develop collective advocacy and partnering skills. Perhaps such networks could be informed by, or partner with, a new NIH-wide scientific interest group on religion and spirituality[4] that was launched in October 2020, with an inaugural talk by NIH director Francis Collins (RSHSIG, 2021).

Will such inputs generate the needed change? By themselves, probably not. Current NIH and NIMH strategic plans still fail to even acknowledge religion and spirituality as factors (NIH, 2021; NIMH, 2021). More generally, the NIH still has a very long way to go (for some stark statistics, see below, Appendix B). But if adequate numbers of concerned professionals each give helpful inputs when opportunities arise, and alert each other to these opportunities, such efforts can support and synergize with other needed steps. And there are precedents for recognition, even within NIH. For example, in the early 2000s, the NIH publicized two program announcements (PAs) and a request for applications (RFA) focused on religion and/or spirituality – see below, Appendix C. And in the intervening years, the evidence base has grown more massive, progress has been made in understanding clinical relevance (e.g., Balboni & Peteet, 2017; Rosmarin et al, 2021; Vieten & Lukoff, 2021), some facets of the topic have received unprecedented attention in the public health literature (e.g., Idler et al., 2019), and potential new collaborators and sites for networking have emerged, such as the NIH's new scientific interest group, the Religion, Spirituality, and Health Scientific Interest Group (RSHSIG, 2021).

What efforts, and what progress, will emerge? Watch this space – the PHRS *Bulletin* – but also watch elsewhere. Consider pitching in to support

such efforts, in a manner and scale that is comfortable for you. And consider telling us about your observations and/or efforts. We should alert each other to information and opportunities. Together, inch by inch, we can bring about the needed rebalancing.

Appendix A: Submitted Comments

Here are three types of comments – short, medium, and long – that were submitted through the NIMH website as part of public input to inform the current NIMH strategic plan (NIMH, 2021):

David Rosmarin submitted a brief comment:

> I was disappointed to not see any mention (at all) of spirituality or religion in the strategic plan. The vast majority of Americans in general, and mental health patients in particular, profess spiritual/religious beliefs and engage in regular practices that have been clearly linked to many facets of mental health and wellbeing, and the statistical majority of mental health patients report a desire to address spiritual/religious life in treatment. NIMH should be addressing spirituality as an important and clinically relevant facet of human diversity. It's time for an RFA.

Brandon Vaidyanathan submitted a slightly longer, medium-length comment:

> While I commend you on the development of a strong strategic plan, I notice there is no mention of religion, spirituality, or faith-based communities. This is a serious oversight given that (1) a large proportion of Americans maintains strong religious/spiritual commitments, (2) an overwhelming body of research establishes relationships between religiosity and mental health outcomes, and (3) faith leaders are often the first recourse for many Americans facing mental health challenges. I strongly urge you to consider expanding your strategies under objectives 3.3, 4.1, and 4.2 to include dialogue and partnerships with faith communities, especially among racial/ethnic minorities, and potentially testing collaborative interventions in these communities. Also, as part of your goal of improving inclusivity and diversity in workforce development, it is important to invest in developing cultural competencies of mental health professionals in matters of religion and spirituality to better engage with clients and their faith communities.

Doug Oman and Katelyn Long submitted a longer, more expanded comment that identified specific places in the draft plan where text might be modified to include mention of religion/spirituality:

> As co-leaders of a national network on public health, religion, and spirituality (publichealthrs.org), and co-editors of a public health, religion, and spirituality bi-annual bulletin (http://www.publichealthrs.org/bulletin/) we strongly urge the NIMH to include religious and spiritual (R/S) factors in its forthcoming strategic research agenda. Religion and spirituality are not fringe issues; they are issues of central importance in the lives of the majority of Americans and issues of essential interest to public health given their vast influence on mental health, meaning making, and conceptualization of the self. Additionally R/S factors facilitate or hinder various forms of mental health promotion and treatment. To ignore or exclude R/S factors blinds researchers and policy makers to critical dynamics impacting mental health in America. It also notably undermines the ability of NIMH to beneficially inform the activities of other NIH institutes focused on physical health, for which religious/spiritual measures have been linked to longevity differentials of approximately 7 years in the US general population, and nearly 14 years in some minority populations (i.e., African Americans). For more background on the interaction between R/S and public health, please see Oman, D. (Ed.). (2018). Why religion and spirituality matter for public health: Evidence, implications, and resources. Cham, Switzerland: Springer International. https://doi.org/10.1007/978-3-319-73966-3. (for longevity see pp. 31, 55-58)
>
> The draft plan contains numerous text locations where religious/spiritual factors could cogently be mentioned without constructing additional

objectives or strategies (which should also be considered for this or subsequent strategic plans). For simple ways to start revising the present draft plan, we encourage you to mention religious/spiritual factors in multiple locations, perhaps all locations suggested below. Failure to include any mention/acknowledgement of religion/spirituality as factors of influence risks conveying the impression that in this respect the plan is intentionally or unintentionally prioritizing an outmoded and prejudicially narrow scientism over evidence-based science that recognizes the power and importance of these factors, recognized as influential since the time of Emile Durkheim, and now investigated in more than 3000 empirical studies, 120 systematic reviews, and 30 meta-analyses (see Oman & Syme, 2018, https://doi.org/10.1007/978-3-319-73966-3_15). Some textual locations for appropriate inclusion within the draft plan (possible insertions in CAPS):

- Page 12, section on "A Comprehensive Research Agenda": "In addition, studies should include participants from diverse racial and ethnic backgrounds, and across gender identities, RELIGIOUS AND/OR SPIRITUAL IDENTITIES, socioeconomic status, neurotype, and age – offering the best possible representation"
- Page 12, section on "Prevention": "…and in different settings (e.g., families, schools, healthcare, WORKPLACES, RELIGIOUS communities, OTHER COMMUNITY ORGANIZATIONS)."
- Page 13, section on "Environmental Influences": "The environment includes natural and built components, individual factors, such as the microbiome, and social factors, such as cultural/RELIGIOUS milieu, family structure, poverty, and neglect."
- Page 22, section on "Goal 2: Examine Mental Illness Trajectories Across the Lifespan": "Further, to provide new therapeutic avenues to prevent and treat mental illnesses we must identify factors, such as social, CULTURAL/RELIGIOUS and environmental (including trauma), and molecular-, cellular-, and system-level mechanisms affecting typical and atypical development."
- Page 23, section on "Strategy 2.1.A: Elucidating the mechanisms contributing to the trajectories of brain development and behavior": "Examining individual differences and biological, behavioral, and environmental (including social, and cultural AND RELIGIOUS/SPIRITUAL) contributors to heterogeneity in risk for and resilience from mental illnesses across the lifespan, trajectories of illnesses, prevention and treatment interventions."

Appendix B: Overview Statistics on NIH Funding of Religion and/or Spirituality Research

Across 27 institutes and centers, the NIH currently funds over 100,000 grants. Various descriptor fields of these grant projects, such as their titles and abstracts, are freely searchable online (go to https://reporter.nih.gov/). Searches conducted on 7 October 2021 reveal that among 100,424 active projects:

- "Spirituality" or "spiritual" as words appear ANYWHERE in the abstracts of only 0.06% of active projects (62, link), and only 0.003% of titles (3 active projects, link);
- "Religion," "religious," or "religiosity" as words appear ANYWHERE in the abstracts of only 0.10% of active projects (96, link) and only 0.004% of titles (4 active projects, link).

Similarly, searching the total database of 2,579,882 project records for the past 36 years – since 1985 – reveals that recognition of these terms in active projects hardly surpasses and sometimes falls below the historical baseline: Spirituality-related words historically appeared in 0.05% of abstracts, link, and 0.006% of titles, link; religion-related words have appeared in 0.09% of abstracts, link, and 0.009% of titles, link.

Yet the vast majority of tax paying US adults – who effectively fund the NIH – profess spiritual/religious beliefs, engage in regular spiritual and/or religious practices, and value spirituality and/or religion to a moderate or greater extent (e.g., Newport, 2012, 2016), and all of these – as well as nonbelievers – can benefit from the better practice that would flow from better comprehension of spiritual and religious factors.

Appendix C: NIH Funding Initiatives with Titles that Mention Religion and/or Spirituality

- RFA (February 7, 2000): AA-00-002: "Studying Spirituality and Alcohol" – "Commit up to $1 million in FY 2000 to fund 7 to 10 new grants in response to this RFA"
- PA (June 22, 2004): PA-04-115: "Religious Organizations and HIV."
- PA (May 9, 2006): PA-06-401: "The Influence of Religiosity and Spirituality on Health Risk Behaviors in Children and Adolescents (R01)."

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[4]^Individuals without an NIH affiliation may subscribe to the Religion, Spirituality and Health Scientific Interest Group's external email list by signing up here: https://list.nih.gov/cgi-bin/wa.exe?A0=RELIGION-SPIRITUALITY-HEALTH-EXT

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Interview with Rabbi Professor Nancy E. Epstein

Jessie Washington,[1] Ashika John,[2] and Angela Monahan[3]

Editors' Note: We are pleased to present the fifth 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 Rabbi Nancy Epstein, MPH, MAHL, Professor in the Department of Community Health and Prevention at Dornsife School of Public Health at Drexel University. Rabbi Epstein was interviewed for the *PHRS Bulletin* by graduate students Jessie Washington of Emory University and Ashika John of U.C. Berkeley, working in conjunction with Angela Monahan, an ASPPH/CDC fellow at the Department of Human and Health Services.

Angela Monahan: You received your MPH from the University of North Carolina, where you studied with Guy Steuart. What were some of the important things that you learned from Dr. Steuart about public health and how they were relevant to understanding relations between religion and public health?

Nancy Epstein: Thanks for that wonderful question. So, I did my MPH as you said at UNC Chapel Hill in health education, now it's health behavior. I didn't fully understand what health education was when I got there. The perspective that Guy Steuart brought and that the whole department embodied was health education as community organizing, development, and engagement in the most authentic way. I flourished with that. The perspective that I got in my MPH has infused and been the center point of everything I have done in these forty plus years; and I've done a lot of very different things. I've spent 20 years in the legislative world working with state legislators on a whole array of policy issues from hunger and nutrition, disability issues, long term care, Medicaid, health insurance – just really the whole gamut of health and human services. Then, I became a rabbi when I was 50 years old. At the time that I entered rabbinical school in 2000, I started teaching part time at Drexel University, in what is now the Dornsife School of Public Health, where I have been for 22 years. Having had 20 years in the policy world, and during those years working for a medical center and doing grassroots organization, and now being in higher education, all those different things that I've done all grow from the centerpiece of what I learned in my MPH program.

Rabbi Prof. Nancy Epstein

So, why did I become a rabbi? In the mid-eighties when I was working for the Texas Senate, we would be in meetings and at a certain point, the legislative committee would go into executive session and all the lobbyists and staff had to leave the room – we'd go hang out in the rotunda. What I noticed was when everybody was talking, they weren't talking about the policy or budget issues that we were there for – they were talking about their lives, their marriages, their kids, their aging parents, and just how to cope with life's inevitable changes. Even people on opposite sides of issues would join together around basic life cycle issues. I said to myself, "I really want to be working at the heart of what matters." It just became clear to me that relationships are the core. They are the strength of all our work. Even in my legislative work, I was always building coalitions

and those were always built on relationships. I realized that I wanted to be working to promote more love in the world. More compassion, more respect, more dignity. As the public health field has been getting more and more data driven, the question then became how to really bring the values back into the conversation, which also included the values of partnership building and real collaboration. It occurred to me over time that becoming a member of the clergy was a wonderful way to capture the things that we were not gathering data on at the time but were still vital for human life and, therefore, vital for population health and the health of communities. So, I went to rabbinical school. In my work in public health and in my work in religion, spirituality, and health, it's always been about building those bridges, finding what's similar and respecting what's different; and then finding ways to integrate the differences so that we can still work together.

I started teaching a doctoral seminar on faith, religion, spirituality and health in 2006. We really started looking at values and discovering the wealth of research on religion, spirituality, and communities, much of which was unknown to my public health colleagues. So many people didn't know that research [in religion and health] existed. Even in the late nineties, before I started teaching the course, I didn't know that research existed. I've been really privileged to help grow this field of religion, spirituality, and public health with my own small contributions of, "How do we teach about it? How do we think about it?" Back to Guy Steuart, the social ecological model grew out of his and other people's thinking. With regard to religion and spirituality at the level of the individual, so much of that revolves around finding ways to communicate health information so that it's not in conflict with people's religion and beliefs. And of course it's important to look at how we incorporate religion and spirituality at the community level. With the work of the black church, you know that's where we have one of the largest bodies of evidence, writing, and research. It makes all the difference in the world to be able to find what's congruent with congregations and with the life of congregations – and the life of temples, mosques, Masjids, and synagogues; and find ways in which we can educate religious leaders so that they become purveyors of public health.

We organized a training in Philadelphia for religious leaders 10 years ago on trauma. Philadelphia is the sixth largest city, with one of the highest levels of deep poverty, a very high percentage of kids living in poverty, and astronomical numbers of homicides and incidents of gun violence. Who is on the front lines? Congregations and religious leaders. The question then was, how do we begin to educate our religious and lay leaders, and congregations, about mental health and trauma? We build a system of community supports out in the field, especially when so many people who are encountering and being involved in trauma, violence, and mental health issues, don't have access to or don't go to the health care system because there's so many barriers. Philadelphia has been a big leader in training clergy around trauma and mental health. What I learned from Guy Steuart has infused everything I've done, because the core is really how do we bring people together? If we can't bring people together and build the bridges and relationships to walk together, we won't be able to solve these compelling problems that we have.

Jessie Washington: When you were working as a lobbyist, did you experience religion and spirituality as relevant to your work? You touched on it already, but if there was anything else that you could speak about regarding religion and spirituality during that time and how that became relevant to your work in the health-related policy advocacy field, we'd love to hear any of your thoughts.

Nancy Epstein: As you're asking that question, I'm thinking that there's religion and spirituality where it's explicitly discussed as part of the policy conversation, and there's religion and spirituality where it's not talked about so much, but it is an important part of people's lives (i.e., elected officals/policymakers). I would say in the explicit policy world, we didn't talk much about religion

and spirituality except when issues came up about sex education or family planning; those were the issues where the lobbyists who came out had different views, and often the positions they took were based in their religious outlook. Other than that, at least in my experience, and again it was several decades ago, religion was often not talked about, but it was always there.

I was working in the South and so these issues were always there. One way also in building relationships, and one of the things I learned from Guy Steuart which is very relevant here – something he would call "the inside view", is understanding how you can come to understand the world through the eyes of people you're working with, people who see the world often differently than you do. Today there's a big emphasis on empathy. That's one way to be very sensitive, resonant with, and see the world through other people's eyes. In anthropology, there's something called the emic view, or how you see the world as an outsider to try and understand what the world looks like through other people's eyes. Guy Steuart was a big proponent of how you get that inside view, that emic view, to really understand where people are coming from. At a political and policy making level, it was really useful because, as a lobbyist, you're trying to engage elected officials to vote for something that you're working on. I was working in a state that was not a big proponent of welfare. When I was working on issues of hunger, we were very successful in passing legislation because we figured out ways to try and understand, through the eyes of individual legislators, what would help them support legislation to address hunger and nutrition. For some, they had a strong Christian commitment to help people who are less fortunate. For others, that wasn't a driving force – they were interested in the medical issues of trying to prevent poor nutrition and poor pediatric outcomes. Often religion was a big driving force for people. Public service for many is driven by a desire to serve. We as public interest advocates had to really become versatile to understand different religions and worldviews so we could find the commonalities and a way to negotiate around the differences. In today's policymaking world and population of elected officials, religion has become a wedge, in many cases. It's a challenge, but I think the opportunity of finding ways to come back and focus on our shared human experience, rather than focus on our differences, is always there.

Ashika John: In the early 2000s, you served as a chaplain for the Abramson Center for Jewish Life and the Hospital of the University of Pennsylvania. In your role as chaplain, did you see firsthand how many people drew on religion or, perhaps in some cases, were challenged by religion in times of health crisis?

Nancy Epstein: The beginning of my pastoral journey began the summer of 2002, when I started training in Clinical Pastoral Education (CPE). I'm still on this journey – my rabbinic colleague and I are looking at how to provide pastoral and spiritual support to heath care providers. Patients and the whole array of staff need support. As a chaplain, I really got to understand that our role was to serve patients and to be there as a spiritual support for clinical staff colleagues and for each other, the chaplaincy staff. For example, all of the chaplains and interns in CPE did overnights in the emergency room in the trauma bay about once a week during the first summer that I trained. It was one of my first overnights that I was sitting and waiting with a mother of a young black man who had been shot. It was a fatal shooting, but he was still alive in the trauma bay being treated. He was eighteen and I think his mother was in her mid-to-late thirties. It was just she and I waiting that night, around two in the morning. She told me a story that has stayed with me that I've shared throughout these years, and I share it pretty often because it changed me.

It was August; she was wailing and said, "He was supposed to be going to college now. He was supposed to be leaving now for college." She told me a story that a year and a half earlier he had gotten involved in drugs – at 16 and a half. The night he was shot, he was at his girlfriend's house, which was around the corner, and she was sitting on a porch. She heard gunshots and one of the kids

in this neighborhood rode his bike by and yelled "Miss, they got your boy." While we were in the waiting room, she kept saying, "He had no hope. He had no hope for his future." And so, I sat there, as a rabbinical student and a chaplain in training, who was at the same time a professor of public health three blocks away and a long-standing public health professional, thinking, "What's wrong with this picture?" How can we all take responsibility and care about the futures of all our children? To me, that was a religious question across religious traditions. It's a multifaith question, a human question. How do we raise up the children that live in our midst and support them so that they can all have viable futures?

After that I worked in a Jewish nursing home that also had assisted living, and I felt so well-used. As a chaplain, all of me was being used: the public health professional, health care provider, rabbinical student, and pastoral caregiver. Prior to that in public health and prior to the development of this movement of religion and spirituality, we were leaving out this huge part of human life. How can we promote healthy communities if we're not integrating religion, spirituality, and our relationship with the numinous – what we can't name, or even what we can name? How do our congregations become healthy communities themselves? By healthy communities, I mean that they're agents of public health and promoting the health of their congregants. That's also the beauty of the role of religious leaders, as exemplars who can speak from the pulpit and train and support lay leaders and religious leaders, so that all of us are working for the public health. I think it takes all of us to create a healthy society. That sense of inclusion comes out of our religious traditions, and we are incorporating it in a kind of non-theological way into public health. All the religious traditions have a core of social justice. It's a natural thing for religious communities and public health to work together.

Jessie Washington: We have already discussed what drew you to becoming a rabbi after your public health career was underway; but since you've been a rabbi, has being a rabbi in any way changed how you do public health?

Nancy Epstein: Being a rabbi changed me as a person. After 20 years working in the policy world, I was somewhat burned out. I had always been studying part time on the side, often religion and spirituality, while I was working full time. After 20 years, I decided that what was really important to me was to flip the priorities: study full time and work part time. I was a full-time rabbinical student taking five courses and I had three part time jobs. Studying filled up my coffers, and I still study. Being a rabbi, we're always studying. We have a beautiful process we call "havruta" where we study with another person. We're not just studying on our own. It's that dialogue – discussing, debating, and interpreting that's vital. As a result of becoming a rabbi in 2006, my whole self was changed.

It was about that time that I first discovered that there were others doing religion, spirituality, and public health. That was also when I taught my first course in religion, spirituality, and public health, and when I started to discover, also, that there was a lot of data. So then, as a rabbi, I realized I'm not alone and that there's a number of people out there already doing this: Mimi Kaiser, Ellen Idler, Doug Oman, Jeff Levin, Linda Chatters – there were a lot of wonderful people I hadn't discovered yet. At about the same time that I became a rabbi, I got to become a member of this cohort of people to begin to move these ideas forward.

I often say to my faculty colleagues here at Drexel that I think I have a different lens than they do as researchers. The other lens I have to public health is as a clergy member who officiates at life cycle events, such as funerals, weddings, and baby namings. I also serve as a spiritual director at the Reconstructionist Rabbinical College. Being a rabbi has given me an opportunity to do a lot of things, as well as being a chaplain, and being free to knit it all together in new ways. I'm always working to find the common human experience and to find pleasure in what's different. What's different doesn't divide us but adds more nuance

to what brings us together, because we're all human. Being a rabbi also gave me the standing to talk about things like love, compassion, mercy, and hope. I think about that example I shared with you from the emergency room. If I had continued as only a public health policy person or if I had gotten my doctorate and was a researcher, the drive would still be on research and data, but I wanted to talk about the values and in those days, I didn't know we had data to support those values. I'm not a researcher – it's not in my gut. I'm a community organizer, a lobbyist, an advocate, a chaplain, a teacher. I want to be in the community, get my hands dirty, talk to everybody, and find common ground. I wanted to be a rabbi to talk about what matters, and I've been able to do it in a way that I think is far greater than if I was not a rabbi.

I got involved in the arts and public health in the last few years and here at the Dornsife School, we created a new graduate minor in arts in public health, which is now an exploding field. It grew out of my work in religion and spirituality. As religion became more divisive, I said I have to find another way to approach this because spirituality still turned off some people. Arts is kind of like a secular version of spirituality because people are bringing their full creative spirits and addressing the numinous – bringing values that matter into actual expression. Getting involved in arts and public health has been a complete outgrowth of my commitment and work in religion and spirituality.

One of the things I learned from Guy Steuart was everything is public health, and everything relates to your health. Not everything is specific to your health, but everything relates to your health. Everything affects our lives and therefore affects our health. As a rabbi, one of the beautiful things that I love to talk about is the word Shalom. People often translate it to mean "peace", but it also can mean "hello" and "goodbye". Its root in Hebrew is a three-letter base that is related to being full, complete, or wholly well. It's like body, mind, heart, and spirit – completely well. You don't have peace unless you're completely well. In Hebrew people ask, "*Ma Shlomcha?*" or "How is your Shalom today?" In the Jewish tradition, we have this wonderful model of Shalom that totally supports public health, our complete well-being as individuals, as communities, and as a society. This beautiful merger between my life as a public health practitioner and my life as a rabbi – I'm so grateful for it.

Ashika John: What has the teaching experience in your doctoral level course been like, and what's been most memorable? Are there any ideas that you wish all public health graduate students could take from your course?

Nancy Epstein: We expanded the course to masters students, so I've even had art therapy students in it. I just love teaching and I get so much energy from it. I invite our students to reflect on their own religious traditions. At the beginning, I have them write papers on subjects like social justice, through their own religious traditions, and then I have them explore the same topics through the lens of other religious traditions. We then bring it all back to public health and we look through a social ecological model. We also look at the changing religious landscape in the United States, how we have more people now identifying as non-religious. I love teaching because I get to learn a lot from my students.

I have a service component in the course. In the last few years, the students have volunteered to be part of radical hospitality with Metropolitan Ministries, which serves people who are houseless. As well as reading, writing, and hearing from guest experts, like Doug Oman, they also reflect on their experience in the service part of the course. I love it because they're out in the field doing some volunteer work, they're reflecting, they're learning intellectually, they're exploring their own roots, and they're learning about other people and, again, connecting all the bridges.

The big focus of the course is the overarching social ecological model. I'm trying to get into research and practice, and the role of religious leaders. You have to focus on the role of the black

church because that's the beginnings of really integrating religion and spirituality into public health. When I was a student in the 70s, there was this wonderful project, led by John Hatch, with a whole team of people working across North Carolina with the black Baptist churches. They incorporated the lay health advisor model of training leaders, the influencers and real leaders in communities who were not always the official leaders. They gave them training around chronic disease and gave them information about how to make appropriate referrals. Those lay leaders became informal peer advisors in their churches. That was a wonderful model that led in many ways to the development of community health workers. That work totally inspired me. When I got into religion, spirituality, and public health, I had to draw on this model that has now gone viral over the decades, because that's where religion and spirituality come together in the congregation. That was the model for why we train religious leaders and lay leaders in mental health and trauma because they're on the front lines. Everything done at the service delivery level needs support at the community level for the desired health behavior to be maintained and sustained over time. I'm a big believer in learning from history, and we have so much to learn from the black church about how to really work with congregations and communities. We have to stand on the shoulders of those who came before us. As you can tell, I am passionate about this work, and I believe in it.

Jessie Washington: What's the one thing that you want people to take away when they encounter you, your teaching, and your way of being in the world?

Nancy Epstein: Be honest, tell the truth, and talk. Be willing to share truly who you are. Even more importantly than talking is to ask questions and to be genuinely curious and open to learn from everyone you meet. Every community is different. How do we enter a community with humility and deep respect, with questions to learn from others, so we can find ways to work together? That's the centerpiece of who I am as a rabbi, as a public health professional. Be willing to learn from everyone.

Jessie Washington: Thank you, this has been very inspirational.

Nancy Epstein: I have one last thought: I think of myself as an encourager. Just simply being encouraging to people who, often, are students and people who are out in the field – to just have these kinds of conversations because we all need to be encouraged. I think that is also the nature of religion, spirituality, and relationships. How do we support one another? We all have ups and downs, so for me, I like to be encouraging. It's a blessing and a way of bringing blessings into others and building relationships.

Angela Monahan: That's what life is about: relationships and connections.

Nancy Epstein: And that's what public health has to be about. That's the core right there.

Jessie Washington: Yes, thank you – we can't thank you enough.

Nancy Epstein: It was great to be with you all, thank you so much.

This interview with Rabbi Professor Nancy E. Epstein took place over Zoom on October 1, 2021. The transcript has been edited for clarity and brevity.

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Learning the Language of Another: How Training in Religion Prepared Me to be a Public Health Practitioner

Ashley Meehan[1]

Editors' Note: The PHRS Bulletin *regularly features accounts and reflections from early career professionals in public health about their discovery, training, knowledge, work, and reflections upon spiritual and religious factors in public health.*

Like many, my interest in religion, spirituality, and public health emerged from lived experience. As I look back, I can now see how I observed these dynamics in action long before I began my training in public health. For example, while on a church mission trip to Guatemala during my undergraduate career – an experience I look back on now with mixed assessment – I witnessed how much care and how many support services were provided to children orphaned by HIV/AIDS from a group of local, dedicated nuns. Religion was doing a good thing; it was motivating individuals to care for children who needed to be cared for in their community.

While in Uganda for study abroad a year and a half later, a local organization working to care for people living with HIV/AIDS explained to me that when doctors or clinics advertised health clinics, very few people would attend. However, when local faith leaders advertised the same events, most of the community attended. During this trip, I began to understand religion as both a personal and individual experience as well as a social influence with meaningful impacts on our health.

As I set out for my graduate public health education, I was immediately drawn to the Religion and Health collaborative opportunities at Emory University, specifically the Religion and Health Certificate. Learning from faculty at the Rollins School of Public Health and from faculty at the Candler School of Theology was an unparalleled opportunity for me. Completing the Religion and Health Certificate required a mix of theoretical and stage-setting courses, as well as practice-based courses like developing faith-based funding proposals to improve health, reviewing case studies from global contexts, and holding mock debates about some of the most pressing issues related to religion and sexual health.

The most important thing I learned from both the theoretical and applied courses was that I was learning a language that my other public health peers were not. I began to notice that theology and public health students were starting to understand each other in new ways and were able to communicate using shared language and mutual respect. This bridge building happened quietly and slowly through my courses. Simultaneously, I started to notice the ways in which my public health peers without this training approached not only religion, but other moral frameworks not rooted in western biomedicine too. While my peers were and are incredibly thoughtful, many talked about religion and faith systems as things that needed correction, viewing people of faith as those who only believed and practiced because of a lack of knowledge. Once I noticed these things, I couldn't unsee them – and moreover, I saw that the broader field of public health also holds these biases. I reached a point where I questioned if I should even be pursuing public health. Luckily, I had Mimi Kiser and John Blevins as mentors who had been working in this intersection and encouraged me to stick with the 'messiness' in which I was finding myself.

I'm glad I stuck with it, because having training in religion gave me a better understanding of the social determinants of health. My time with Emory and the Interfaith Health Program taught me to step back and view socio-contextual factors as interconnected and powerful to both positively and negatively impact our health. This curriculum also bolstered my systems-level thinking, allowing me to be a well-rounded public health practitioner. There have been concrete, tangible, and explicit skills that benefit me in public health as a result of this training: my training is rich in teamwork with people who think, see, and act differently than I do; I have been able to practice hard conversations with no apparent or easy solutions; I have a strong ability to identify common ground for effective partnership building; and I am equipped to engage faith communities or faith-based organizations because I recognize their language. There are many additional skills that can be thought of as less concrete and not as tangible, but equally important. My training fostered a deep respect for different world views, which has allowed me to really build muscles for empathy; I am able to serve as a "traffic stop" in public health settings to ensure public health action is equitable and avoids paternalistic assumptions on the basis of religion.

These skills have benefitted me in my current position in homelessness and health, which very rarely has black and white answers. I do not shy away from the complicated and messy borders of public health and housing services; I lean into the gray space and feel comfortable navigating it. In partnerships between public health and housing services, I am able to come to the table and say, "I'm listening, and I want to find ways we can value each other's needs and goals at the same time."

While supporting an emergency intake shelter for refugees during COVID-19, I had an "aha" moment where all of my courses and practical experiences set me up for success and I realized how important this intersection was. There was a local faith group that wanted to hold religious services at the shelter during an important time of religious observation for their faith tradition. It was clear that those staying at the shelter were wanting and needing spiritual rest and care, but many agencies and organizations working on site couldn't see how this would be possible given the need for COVID-19 prevention measures like masks and distancing. Other staff were fully expecting the public health team to reject the idea immediately. Instead, two logistics coordinators and I met with local faith leaders to discuss the rituals performed on these holidays, their importance, and how they could be practiced in modified ways to minimize potential disease transmission without sacrificing what constitutes faithful action. We practiced walk-throughs and trained their volunteers on proper PPE usage and the modified practices. The celebration of the holiday was beautiful and immediately lifted spirits of everyone on site. While there are many who could have done the same thing, I truly believe my training at this intersection prepared me to make that situation the best it could be, marked by a deep respect and love for one another.

Through personal experience and my training in religion and health, I know how important religion can be at an individual level. I know what it feels like to weigh decisions of present, earthly gratification with the promise of eternal salvation and freedom. I can empathize with people who hold value and seek guidance from both the physical world and the meta-physical world. This inspires and requires me to be flexible in public health. Working at the intersection of religion and health necessitates creative communication and bridge building, which are critical building blocks to effective public health. I would not be the public health practitioner I am today if it weren't for my training at the intersection of religion and health.

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[1]^Ashley Meehan received her MPH in Global Health with a Certificate in Religion and Health from Emory University in May 2019, and worked at Emory's Interfaith Health Program (IHP) during the 2-year graduate program. She is currently working in homelessness and health at a public health agency (Ashleymeehan20@gmail.com).

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Resources & Updates: Fall 2021

PHRS Staff

Editors' Note: This section emphasizes resources at the intersection of religion/spirituality and public health, as well as major organizations that at times address these intersections. Please see the "Resources" tab on the PHRS website for more content, and please send new potential content to this section to: phrsadm1@publichealthrs.org and phrsadmin0@publichealthrs.org

New Research

- October 2021: Faith-Based Organizations and SARS-CoV-2 Vaccination: Challenges and Recommendations. (Levin, Idler, and VanderWeele)
- October 2021: Pew polling report on religion and COVID-19
- September 2021: Religious or spiritual coping, religious service attendance, and type 2 diabetes: A prospective study of women in the United States. (Spence et al.)
- June 2021: Special Issue in Religions "Pandemic, Religion and Non-religion"
- June 2021: Psychological and spiritual outcomes during the COVID-19 pandemic: A prospective longitudinal study of adults with chronic disease (Davis et al.)
- March 2021: Religion and the World Health Organization: an evolving relationship. (Winiger & Peng-Keller)
- February 2021: Religious service attendance typologies and African American substance use: a longitudinal study of the protective effects among young adult men and women. (Hodge et al.)
- January 2021: Religion and Measles Vaccination in Indonesia, 1991–2017. (Harapan et al.)
- June 2020: Building towards common psychosocial measures in U.S. cohort studies: principal investigators' views regarding the role of religiosity and spirituality in human health (Shields and Balboni)

NIH Spirituality Listserv

- **New Listserv**: If you would like the join the newly subscribable NIH Spirituality, and Health Scientific Interest Group Listserv, click here.

Upcoming Conferences & Webinars

- **Ongoing conference**: World Health Organization and Religions for Peace Global Virtual Conference, October 20-December 3, 2021: Conference Website
- **Upcoming Webinar**: December 14, 2021: NIH Religion, Spirituality, and Health Scientific Interest Group, "Religion, Spirituality and Health: Review, Update, and Future Directions". Sign up here.
- **Upcoming conference**: Conference on Medicine and Religion, March 13-15, 2022: CMR conference website

Recent Conferences & Webinars

- American Public Health Association Annual Meeting, October 22-27, 2021: Caucus on public health and the faith community sessions
- March 2021: Webinar: Sacred Work Science, Religion & Human Health (Dr. Ellen Idler, Dr. Emmanuel Y. Lartey)