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Editors' Introduction: Issue #2 in a Time of COVID-19

Welcome to the second issue of the *Public Health, Religion and Spirituality Bulletin* (*PHRS Bulletin*), published by the Public Health Religion and Spirituality Network (PHRS Network). When we began to develop this issue in January, we never could have imagined how differently the world would look by the time of publication. While the articles in this issue were not initially designed to address COVID-19, some of our content unsurprisingly evolved alongside our changing world. For example, lessons for the current pandemic are mentioned by Ellen Idler, John Blevins, and Mimi Kaiser in their report on a new online exhibit about the Ebola outbreak in West Africa, the critical role of the faith community, and its relevance to today. Similarly, Tyler VanderWeele and Katelyn Long write about the important role of religious communities in times of crisis, and our new resources article highlights a number of COVID-religion-spirituality related resources.

We are also pleased to include a number of articles that we hope will serve as welcome and engaging reads during our extended times in relative isolation – as well as providing lasting value. We begin with an interview with Jeff Levin, a pioneering epidemiologist who has studied religion and public health for over 30 years, published several of the seminal papers in the field, and remains passionate about the field and its future. Next, Everett Worthington uses both wit and candor to describe his journey from psychology to becoming a renowned researcher on the topic of forgiveness, and his burgeoning engagement with public health. Susan Holman, a professor of religion and the healing arts, shares her insights about ways that public health professionals can meaningfully engage historic religious resources to inform and deepen modern practices at the intersection of religion, spirituality, and public health. Each of these articles can be read online or printed in PDF format either individually or as a whole issue ([link to PDF]), and please do consider sharing these resources with colleagues in your own networks.

In the coming months, the PHRS board will convene to review our first two bulletins, the growth of the network, and plans for the coming year. We welcome your ideas for future articles and input about the Network and/or website (see our emails below) as we seek to become a gathering point for those with interest in public health, religion, and spirituality.

Thank you for being a part of the PHRS network, and wishing you and your loved ones well in the months ahead.

Sincerely,
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Interview with Dr. Jeff Levin

Auwal Abubakar,[1] Angela Monahan,[2] and Blake Victor Kent[3]

Editors' Note: We are pleased to present the second 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 **Jeff Levin**, **PhD**, **MPH**, University Professor of Epidemiology and Population Health, Professor of Medical Humanities, and Director of the Program on Religion and Population Health at the Institute for Studies of Religion, Baylor University. Dr. Levin contributed many pioneering publications in the 1980s and 1990s that formulated conceptual foundations for the study of religion and health. Dr. Levin was interviewed for the *PHRS Bulletin* by graduate students Auwal Abubakar and Angela Monahan of U. C. Berkeley, working in conjunction with Blake Kent, postdoctoral researcher at Harvard University.

Angela Monahan: In 1987, with Preston Schiller, you published the first comprehensive review of empirical studies on religion and health. How did you get the idea for doing a review like that?

Jeff Levin: Great question! I was a first year MPH student at UNC Chapel Hill in 1982, and I was taking a class taught by the late Bert Kaplan, who along with John Cassel and Leonard Syme, was one of the founding fathers of social epidemiology. We did some readings and one of them was an unusual study that looked at mortality rates broken out by whether people went to church or not. I thought this was the strangest thing and wondered "Why would somebody do a study like that?" But something in me kicked in and I wondered if there were other studies out there like that. Of course, there was no PubMed in those days, so I had to search by hand through the National Library of Medicine's *Index Medicus* that came out every quarter. By the end of the semester, I had found about 12 or 15 studies which I presented in class and Bert told me I should write it up and send it to a medical journal. Thinking it would be embarrassing to submit a literature review article saying there were only 15 studies on the topic, when really there were, say, 20, I went back to make sure I had found everything. This turned into a wild goose chase that took my weekends and nights for most of the next four years, and by then, I was getting my PhD at the University of Texas Medical Branch in preventive medicine and community health, so this was a side project.

Jeff Levin

By the time I was done, around 1986-87, I had found somewhere north of 200 studies in which some sort of measure of religiousness was used in a quantitative analysis in an epidemiology, medical, or biomedical paper. Preston Schiller, my co-author, was one of my UNC professors. We wrote this paper up, sent it in to an epidemiology journal, and got a very skeptical response. So we published it in the *Journal of Religion and Health* and, naturally, it was well-received there. [*see Levin and Schiller (1987) – Eds.*]

So that literature review started as a term paper in an MPH class, and I use that example to this day,

all these decades later. I tell my own students here at Baylor that as a student, you can do things, you can write a term paper, you can investigate a subject, and it can turn into something. You can publish it and it can even help create a new field.

Angela Monahan: Why were some skeptical when it was published? How did others react to the review?

Jeff Levin: We had sent the paper to *Epidemiologic Reviews,* the annual review journal of *AJE*, and we got great reviews. One of the reviewers was George Comstock, long-time chairman of epidemiology at Johns Hopkins and former editor of *AJE* and who had done many of these studies, and we got great reviews. The editor at the time, whose name I won't reveal to protect the guilty, sent us a two-page, single-spaced rejection letter. Usually, when you submit something to a journal and it gets turned down, you get a paragraph or so of boilerplate. Well, he had two pages of commentary on how absolutely misguided our paper was, and why would we think religion had anything to do with health or wellbeing, and that the idea of an epidemiology of religion was crazy. He used the word "execrable." I had to look the word up in the dictionary, I thought it was a scatalogical reference, at first, but it actually means "worthy of being detested, abominated, or abhorred." Not as bad, I guess!

So, the question of why. A good friend of mine, Larry Dossey, a retired internist and popular writer on medicine and consciousness put it well. Dossey came up with a model of what he called the "Three Eras of Medicine." Era One was about the body only, Era Two was mind-body-centered, and Era Three, which is ongoing, has folded in consciousness or spirit. Back in the 1980s, medicine was still in transition from an everything-is-biological approach to consideration of the mind-body relationship, psychosomatic medicine, behavioral medicine, and psychoneuroimmunology. Medicine was still negotiating that, and here comes a graduate student from Texas proposing an article that said maybe the mind and body aren't all there is that impacts on health and we need to fold in this other dimension, the human spirit, and I think that was too much at the time. Nobody knew this research existed and, in fact, many people in academic medicine were still skeptical over the idea of mind-body connections. The idea that our behavior, attitudes, and beliefs, had anything to do with health, health behaviors, or healthcare use, was still considered controversial.

Angela Monahan: You used the phrase "epidemiology of religion" in an early paper but have expressed some concerns about that phrase. Why?

Jeff Levin: I just think the phrase has been so misinterpreted. To some people who aren't in the public health field, epidemiology is somehow synonymous with demography; so, I think people, including doctors, interpreted "epidemiology of religion" as being about demographic analyses of religion. That has absolutely nothing to do with what I meant. The phrase to me meant studying religion as an independent or exposure variable or construct in relation to morbidity and mortality rates or measures of health and illness, in keeping with the traditional definition of epidemiology, and it somehow got construed into being the quantitative study of religious behavior. That's something that sociologists and psychologists of religion do, which is fine, but that's not what I meant by the phrase.

We still don't have enough good population-health research on religion. By now, yes, thousands and thousands of religion and health studies have been published, but most of them are not really epidemiologic studies; they're good sociology, psychology, and clinical studies, but not as much longitudinal epidemiologic studies with case-control or cohort designs, and that's because historically there haven't been a lot of epidemiologists in the field. Most of the earliest folks that came into this field were medical sociologists or psychologists. Others were physicians like Harold Koenig or Dave Larson. I was different. I was an epidemiologist, who, serendipitously, was originally trained as an

undergraduate in religious studies. So I came at this issue from a different perspective. In the last ten years, another trained epidemiologist has entered the field in a big way, Tyler VanderWeele from Harvard, who is just tremendous. I feel like I've finally got a disciplinary colleague, a junior colleague, who's absolutely brilliant and will exceed anything that I've been able to do.

Angela Monahan: Thinking about the resources and studies you used back then to evaluate causal relationships, what has changed since then?

Jeff Levin: I think three things have changed. The first thing is that we now have large scale, national, multi-wave population studies in which heath and religion variables are included. That wasn't the case back then. Now there are wonderful global data sets, like the Gallup World Poll, the World Values Survey, and the European Social Survey in which there are data available to do multi-wave analyses, prospective longitudinal analyses, or time series analyses. That's the first distinction. The second, speaking methodologically, our bag of tricks is bigger than it was back then. When my mentors and I were trained, epidemiology used to be about manipulating 2×2 tables. With the rise of personal computers and statistical packages, you could learn how to do logistic regression and all those kinds of things. Now there's more, what with Cox proportional hazards modeling and different types of more sophisticated multivariable and dynamic analytic techniques. There are all sorts of things that we can do to get the most out of our data that simply didn't exist back then. So, we have access to data, we have a bag of tools to work through the data, and we also have – thanks to Harold Koenig, especially his *Handbook of Religion and Health* – a bibliographic record of the thousands and thousands of studies that have been done. When I did my literature review in 1987, I found about 200-plus studies. By the turn of the century, Koenig's first edition of his handbook had around 1200 studies. By his second edition ten years ago, there were an additional 3,000. There are probably 10,000 studies now, and people can go into these bibliographic listings almost as a database, and we could even do meta-analyses and systematic reviews based on Harold's handbook if we wanted to.[4]

Auwal Abubakar: Can you tell us about how the NIH and other key funding agencies have reacted to this type of work over the years? What was it like in the beginning, and what is it like now?

Jeff Levin: Well, today this is just a topic like any other topic and you can submit an R01, or any other type of grant proposal asking for support for health-related research and development. Back in the day, the topic was considered so strange that I don't think anybody had ever bothered to submit anything to the NIH. In 1990, I got an R29 grant, a five-year grant for new investigators. I submitted it not through some special RFP or a special request, I submitted it as a regular proposal through one of the existing mechanisms. As a result of my grant and the work of my colleagues, Robert Taylor and Linda Chatters also getting funded, the NIH decided to convene a special conference on the subject. They brought 50 to 60 people together, commissioned some special papers, floated a request for proposals, and created an actual mechanism to fund research on this topic. Ever since then, it's been onward and upward. Before this, there was no mechanism for this. You could propose research on this topic, like anybody proposing research on anything else, and you would hope that the reviewers who got your proposal didn't think it was too strange.

I wrote my proposal in 1989, it was funded in 1990, and I think that was the first empirical study that the NIH ever funded on religion and health. That's not the beginning of the story, though. The NIH, specifically the National Institute of Mental Health, back in about 1980 had published an annotated bibliography by Florence Summerlin, with something like 1,800 references on the topic of religion and mental health. These were books, papers, conference reports, and peer reviewed articles. This was several years before my literature review came out and years before my first NIH grant was funded, so clearly somebody or somebodies were doing research and writing on

this subject and somebody at the NIH apparently knew about it, because they published an annotated bibliography on decades of this work. And to reiterate, this was 40 years ago.

What's so fascinating about those early days, and I'm sure if you were to talk to Ellen Idler or Ken Pargament or David Williams or Harold Koenig or a few other people they would affirm this point: A lot of work had been done, but the people doing the work didn't necessarily know that other work had been done. Hundreds of studies had been published, but nobody knew they were there, and it took an obsessive graduate student to accumulate all of this. Without the bibliographic tools that we have now, there was no easy way to find out what had been published unless you happened to be surveying the journals regularly. The NIH didn't jump on this topic until the 1990s, but they knew about it in the 1970s, apparently, when they compiled the religion and mental health annotated bibliography. The American Medical Association even had a committee on medicine and religion, dating to the 1960s, if I recall, so the subject must have been on some folks' radar, but that doesn't mean that active researchers were getting studies funded.

Auwal Abubakar: While most of your writing has been theoretical or empirical publications for professional audiences, you've also written for broader audiences, as you did in your book, *God, Faith, and Health* (2001). Why did you write about faith/health for a broader audience?

Jeff Levin: That's a great question! In 1997, I had been teaching medical school. I left academia, and was kind of getting burnt out from just doing academic biomedical science and producing work maybe 50 people would read. I thought that this work was very important, I thought the field was very important, but at a certain point, I felt, it needed to reach a broader audience – it needed to enter the public consciousness, if you will. While there had been excellent academic books on the topic, I thought there was a need for a popular book, so I wrote *God, Faith, and Health*. I think a lot of us who are in the academic world become so focused on the narrow, discrete issues involved in our own research, that we lose sight of the bigger picture and lose sight of the importance of communicating what it is we do to the broader audience.

As I've gotten older, I'm thinking about these things more. What do I want to leave behind? I'm happy to leave behind 200-plus academic papers, or whatever number I'm up to, but I'd also like to leave behind works that can communicate this information, not just to scientists, psychologists, doctors, and religious scholars, but to lay people and to educated general audiences, because I think the topic is fascinating and it needs a broader airing. A lot of academics write popular books, and psychologists especially have done well in communicating psychological concepts to the general public. Sociologists have done this less so, but epidemiologists and public health professionals hardly do it at all.[5] I think it's a shame, especially social and behavioral epidemiologists, because the work that we do is so fascinating and so applicable to people's lives. I wish Len Syme or Lisa Berkman or Sherman James or George Kaplan, or others, would write popular works summing up the research they've done throughout their career. I think that would be fabulous and do a lot of good.

Auwal Abubakar: Did it feel like a big change to write for a broader audience?

Jeff Levin: I think where the challenge came in for me was learning how to translate from the academic voice into a voice for the broader audience, but this was a wonderful challenge and it has helped me immeasurably over the years as a lecturer. I think for all of us who are academics, especially academic biomedical scientists, it is in our best interest to take a step back and find ways to put into language what it is that we do so that people who aren't scientists can understand. Not only would this be helpful from an "evangelistic" standpoint, if that's the right word, but it also helps our own clarification for ourselves of what it is we're doing. I'm still doing this, by the way. My latest book, *Religion and Medicine* [Levin, 2020],

is due out with Oxford University Press this spring, and is aimed at a wide audience of both academics and the general public.

Angela Monahan: You recently co-edited the first ever special section on religion in the *American Journal of Public Health*. How was that whole experience?

Jeff Levin: That was a lot of fun! Ellen Idler at Emory took the lead and then I was involved along with Tyler VanderWeele and the head of the Islamic Relief, Anwar Khan. Editing a special issue of a journal is almost like editing a book, except that you're soliciting papers and you don't know what's going to come in the door. There was a review process to take care of, then we did some of our own writing. It was so exciting because there have been thousands of studies published on this topic and they've appeared all over the literature, but to have the pre-eminent public health journal in the world give it's official imprimatur, for the editor-in-chief of *AJPH* to say that we're going to devote a section to the subject, has helped to broaden the platform for this work.

I read Len Syme's interview that he did for the last issue and one of the questions directed to him was, "Are clinicians more open to this topic than public health people?" and the answer historically is yes, absolutely. Public health professionals tend to be more secular or skeptical of faith issues and more politically progressive, which, at times, we must admit, has gone hand in hand with anti-religious attitudes. The *AJPH* special section is historically significant because, we hope, it opens the door to more people submitting to *AJPH* in the future and to other public health and global health journals. That's would be an exciting development, and long overdue. Within academic medicine this topic is becoming more mainstream. Papers have been published in *JAMA*, in *Archives*, in *Annals*, and all the major medical journals for many decades. But until now, this has not yet been a topic that is widely broached and debated within public health circles. So I think by opening up *AJPH* as a potential publishing outlet, it does a lot of good.

Angela Monahan: The section focused on faith-based partnerships rather than on the evidence base or on causality. Why?

Jeff Levin: Well, from the standpoint of the special issue, the editor just wanted us to find a way to broach the topic of religion or faith in a way that would be professionally relevant and more easily assimilated among public health scientists and practitioners. So we made the topic about partnerships with faith-based organizations for purposes of disease prevention and health promotion…who's against that? The aim of the special issue was to talk about the substantial literature of evaluation studies of programs that involve partnerships between faith-based organizations and public health agencies, which is of direct relevance to the delivery of public health and the practice of preventive medicine and health promotion. I think we can appreciate that if we want to reach people, especially underserved communities, we should try to reach them through the institutions in which they are most involved, so these sorts of partnerships and alliances make sense for public health. This is a productive way to broach a connection between faith/religion and health, especially for this audience, rather than going full bore into a theological space or discussing controversial studies of distant prayer, for example. Over the years, *AJPH* has published some good epidemiologic studies, like the famous study by Strawbridge using Alameda County data to look at the effects of religious involvement on longevity. Additionally, Jeremy Kark published a paper on religion and mortality rates in Israel years ago. So, *AJPH* has published research on this topic, but not often. For the special issue, I think we made the right decision to focus on interventions and programs. This was a way to help ease the subject of religion into public health discourse without alienating people.

Auwal Abubakar: What are the major obstacles to growth in this field? And also, what has most surprised you in how the field has evolved?

Jeff Levin: I think a major obstacle is really the same obstacle that's been there since the

beginning; it's the same obstacle that hampers a lot of research in Western biomedicine, and that's a reticence to think outside the box and to think creatively. It's much easier to color within the lines and fill in the blanks than to push the envelope. There's so much wonderful work being done, but there always needs to be a few people in any field that are the ones asking "what comes next, what are the other important questions?"

In recent years there have been some really fascinating studies on religion and health published, and I would love to see them become more prevalent. For years I've been saying, publicly, that I'd love to see the independent religion variables get "softer" and the dependent variables get "harder". By that I mean so much of the work has been about hard behavioral measures of religiousness or spirituality. How many times you go to church? Do you do this, do that? How often do you pray? Do you believe this or that? The outcomes, in turn, have been more subjective measures of well-being or overall health. Nothing wrong with any of this, of course. But I would like to see more of an engagement of the inner spiritual life of people, in terms of concepts like transcendence, one's connections with God, born-again experiences, spiritual states of consciousness, meditation, and so on. Things that are a little less amenable to easy quantitative counts.

At the same time, I'd like to see more dependent variables assess inside-the-body processes: for example, immune system markers and other physiological, pathophysiological, and psychophysiological outcomes; also more studies of cause-specific mortality rates. This is where I think this field should go. I would also like to see more of an explicit link-up with contemporary understandings from molecular biology and genomics. That's where the excitement is for me: thinking about how spiritual states and experiences impact on really harder physiological measures of health status or physical functioning, and *vice versa*. I hope I'm around to see the field evolve in this way.

This interview with Dr. Levin took place on January 27, 2020, via telephone. The transcript has been edited for clarity and brevity.

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[4]^ *As of two years ago, Oman and Syme (2018) had listed and categorized 33 meta-analyses and*

118 systematic reviews published on relations between religion/spirituality and health-related variables. – Eds.

[5]^ *Apart from Dr. Levin's work, another rare example of epidemiologists writing a popular book is Wilkinson and Pickett's (2009)* The Spirit Level: Why Greater Equality Makes Societies Stronger. *Both authors are epidemiologists, and the book became an international best-seller. – Eds.*

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Religious communities and love of neighbor in times of crisis

Tyler VanderWeele[1] and Katelyn Long[2]

The present coronavirus crisis underscores the profound interconnectedness of religion, spirituality, and public health. For example, one of the most pronounced features of the pandemic has been restrictions on social gatherings, including those of religious communities. For many, the inability to gather with their religious communities has been an acute loss during this pandemic, especially for those from religious and spiritual traditions accustomed to gathering in physical locations such as mosques, temples, synagogues, and churches; gatherings which are often understood as a means towards spiritual goods and/or communion with God. Indeed, empirical evidence also bears out the unique contribution of participation in religious services to increased health and well-being (Koenig et al., 2012; Idler, 2014; VanderWeele, 2017). How then ought religious communities navigate the competing goods of gathering together and protecting physical health?

Such questions, while perhaps unusual for some in public health, are genuine and valid among a wide range of religious and spiritual communities and of relevance to public health more generally (Oman, 2018). Thoughtful consideration of these competing goods requires reflection. Gathering in groups amidst the present pandemic not only risks one's *own* physical health, but potentially that of one's community, country, and even, the world. Because COVID-19 is an *infectious* and highly contagious disease, there is more at stake than one's own health. It is in these circumstances that the widely shared religious principle of *love of neighbor* arguably leads to the temporary suspension of religious gatherings (VanderWeele, 2020). Of course, foregoing these gatherings will undoubtedly be experienced as a time of trial and potentially decreased spiritual wellbeing for many; difficulties that must not be overlooked or minimized.

Yet, in the midst of extended periods of isolation from one's religious community there may be other opportunities for spiritual growth; for example, spiritual reading, prayer, offering difficult and painful circumstances to God or a higher power, or family religious ritual and practice. There are also a number of virtual resources such as online services, prayer gatherings, confession, or guided study of sacred texts. Empirical evidence also suggests a variety of mechanisms by which religious services affect physical health and longevity (Li et al., 2016; Morton et al., 2017; Kim and VanderWeele, 2019) including social support and connection, promotion of healthy lifestyles, meaning and purpose, hope, and forgiveness. Even amidst social distancing, there are a variety of ways that one may engage in activities that promote these ends, and help mitigate the effects of suspended religious gatherings. Examples include phone or video calls with friends, family, or members of one's religious community, and reflecting on what is most important in life, one's source of hope, or on relationships which may need forgiveness and reconciliation.

Of course, there are reasons to believe that the meaning derived from religious services will only ever be partially fulfilled by online options and isolated activities (VanderWeele et al., 2017). But, for many, the losses are endured for the sake of love and to preserve the life of others. The suffering experienced by religious communities can bring new growth, a greater hope, a refined set of commitments and purposes, and an empathy oriented towards sharing the suffering of others.

As the crisis lingers, religious communities should also prepare for the way religious gatherings may need to adjust to social distancing requirements that remain beyond formal lock-downs. Such strategies may include gathering in smaller groups, holding meetings throughout the week to distribute crowds, enhancing the cleanliness of facilities, or providing protective gear to vulnerable members of the community. Religious communities can also advocate for better data to help policy makers make informed decisions about the best courses of action to pursue in this and future crises (Pearce et al., 2020). Finally, when this crisis subsides, every effort should be made to fully restore the vibrant, in-person, life of religious communities, for which there yet appears to be no perfect substitute (VanderWeele et al., 2017).

Editors' Note: A series of reflections on religion and health during the COVID-19 pandemic are available in a new special issue of the Journal of Religion and Health *(*link here*), including an expanded version of this article (*VanderWeele 2020*). Our updated resources section also includes a variety of links to materials intended to help religious communities navigate the process of re-opening, e.g., the* CDC webpage for community and faith-based organizations *and Emory University Interfaith Health Program COVID-19* Resources for Faith Communities*.*

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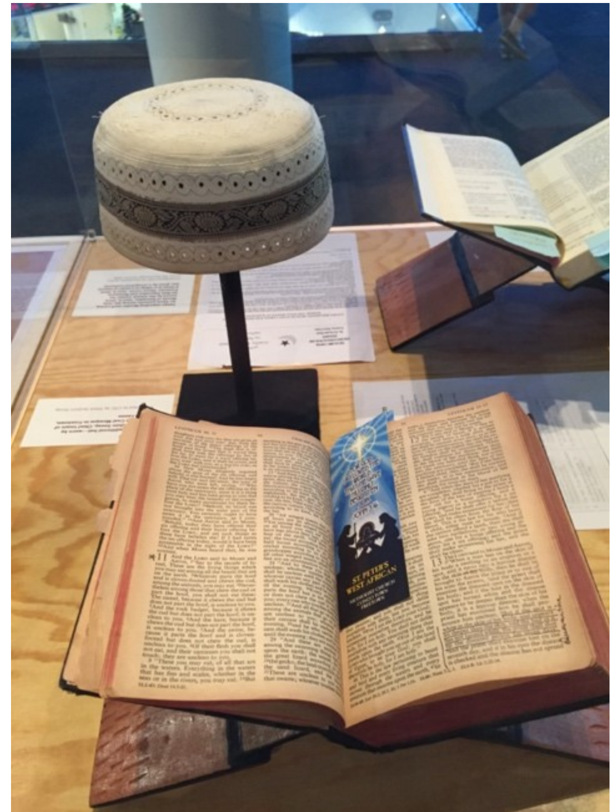
Ebola and COVID-19: Lessons from and for the Faith Community

Ellen Idler,[1] John Blevins,[2] and Mimi Kiser[3]

A not-so-distant mirror of the current pandemic is provided by the 2014-2015 West African Ebola outbreak. We the public now have an easy way to inspect this Ebola mirror and ponder its lessons. As of Thursday February 6, 2020, the Centers for Disease Control and Prevention (CDC) has launched an online digital version of its acclaimed Ebola outbreak exhibit, previously on physical display in the CDC's David Sencer Museum in Atlanta during 2017 and 2018. The digital project, a joint effort of the CDC with students, faculty, and staff of Georgia State University and Emory University, has catalogued every object and installation in the original exhibit, and includes additional materials such as interviews with actors in the medical, public health, and faith communities of Liberia, Sierra Leone, and Guinea. You can access the digital exhibit here: http://cdcmuseum.org/

At the February digital launch event, one of the CDC scientists who led the Ebola response spoke about her pride in the museum's exhibit, and how much she had enjoyed giving occasional tours for visitors. She also mentioned that one of her favorite parts of the exhibit was the section about the faith communities that had played such a pivotal role in the epidemic. At the start of the epidemic, funerals for those who had died of the virus were often a serious source of contagion, as relatives and loved ones prepared the body for burial in the traditional way, often with close contact.

Representatives of Islamic and Christian groups responded to burial contagiousness by playing an important role in revising the World Health Organization's guidelines for "safe and dignified" burials that would be acceptable to bereaved families who needed to honor their dead, and at the same time to be safe. Revising the guidelines was



CDC Museum exhibit showing annotated Bible and Quran used at Focus 1000 meeting of faith leaders, Sierra Leone. Photo Credit: Ellen Idler.

a first step, but getting the message to individual imams and pastors throughout the affected countries was an additional challenge. In Sierra Leone, a national faith-based organization called Focus 1000 met this challenge. Founded by Mohammad Jalloh, a pediatrician who had worked for a number of years with the World Health Organization, Focus 1000 had already established local groups of Christian and Muslim faithful in every district in Sierra Leone before the outbreak. These groups—the Islamic Action Group (ISLAG) and the Christian Action Group (CHRISTAG)—disseminated the guidance

developed by the Inter-religious Council of Sierra Leone to local communities. In a two-day meeting, leaders from the Inter-religious Council searched the Quran and the Bible for teachings that would be relevant to a time of epidemic. The CDC exhibit displayed one of the Qurans and one of the Bibles that had been used by the religious leaders at the meeting, complete with post-it notes and handwriting in the margins. (One is able to see, for instance, the word "quarantine" written beside an underlined text, visible in the photo and also on the CDC site). Those passages became the basis for sermons, khutbahs, and lessons that could be distributed to all faith communities, from national to regional to local mosques or churches. The interfaith meeting took place in late 2014, at the very peak of the epidemic, concurrent with the release of the revised guidelines for safe and dignified burials. Three weeks after these events, there was a rapid decline in cases. The faith community's actions, which in the early stages had been an accelerant for the epidemic, then became an important braking mechanism. You can read more about these events here: https://ajph.aphapublications.org/doi/10.2105/AJPH.2018.304870

Today we are in the midst of another epidemic, this one much closer to home. Once again, religious gatherings and funerals have shown themselves to be sources of transmission of the virus. There has been some tension, covered heavily in the press, between public health messages and religious leaders, some of whom have refused to cease holding large gatherings for services. Fortunately — and despite the wide coverage — this is *not* what most religious leaders in the US are doing. There is a multifaith Facebook group for clergy that has over 7000 members as of this writing on May 19 and is growing daily. It is filled with messages of encouragement and technical advice for clergy coaching each other on how to use Zoom for Sunday School, or writing liturgies for their online services, and considering ahead of time the funerals they will almost surely have to perform. These clergy are funny, sad, thoughtful, and sincere in their desire to keep their congregants safe – *none* of them are disregarding the advice of the CDC on physical distancing and handwashing. They are doing their best to promote safe practices. Moreover, they are focused on caring for the needy and vulnerable in their communities and being a source of support to each other. The message of conflict between religion and public health (science) is unfortunately a common narrative, but it's not the one we should be hearing at this time.

The Interfaith Health Program of Emory University is mounting an extensive web site for resources by and for faith communities, to support their efforts in their congregations and communities. Our main website can be accessed here: http://ihpemory.org/

We welcome submissions! Please use the online submission link below to contribute your "COVID-19 Resources for Faith Communities" documents, web sites, and other materials, which will then be catalogued and posted – we know the readers of this newsletter will have a lot to offer. Just submit a link or document and it will be catalogued and posted after being assessed for the soundness of the content: http://ihpemory.org/covid-19-resource-submission/

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Dancing with the Stars

Everett L. Worthington, Jr.[1]

Editors' Note: In addition to interviews with senior scholars and other features, the PHRS Bulletin includes personal essays written by field leaders and other key contributors. Here, Dr. Everett Worthington uses both wit and candor to describe his journey from psychology, to becoming a renowned researcher on the topic of forgiveness, to burgeoning engagement with public health in his late career.

I have come late to the religion-and-spirituality-in-public-health dance. Sometimes I stand around awkwardly wondering who, if anyone, will dance with me. At other times, I feel like someone who wandered onto the set at Dancing with the Stars (DWTS) and found himself being schooled by twice-winning DWTS pro, Cheryl Burke. Okay, I did participate on the traveling road show for DWTS about ten years ago. My partner, who was actually the talent in our duo, and I unfortunately didn't win. We were stomped by two ten-year olds—a real blow to my fragile sense of self-esteem. I needed some schooling.

April Dawkins Warren and Ev Do a Demonstration

This Reaches Back in Time

I graduated with my PhD in Psychology (Counseling) back about the time dirt was discovered and the Julian calendar was conceived. 1978 if you must know. I joined the faculty in Psychology at Virginia Commonwealth University (VCU) immediately after graduation, and stepped into an ideal job—initially teaching counseling theories, counseling practicum (and supervision), intro to psych, personal adjustment, and adolescent psychology. My department chair in 1978 was Bill Ray, a statistician. When I said, "Bill, I haven't even taken a course in adolescent psychology," there was the briefest pause. Then "Well, you were an adolescent weren't you." Bill did not have a keen sense of empathy.

Armed with my posh $14K 9-month salary, it was still a grueling 3-3 load to start, with three more courses in the summer at about $1000 each. Publishing wasn't the same back in the day when we walked uphill, both ways, in the snow … (well you've heard that story often). We had punch cards for data analysis and one run per 24 hours. A typo on a single card resulted in no results.

Practice, Practice, Practice

I was seeing clients for my licensure. I eventually accumulated enough hours by 1982 to become licensed, and I opened a part-time after-working-hours private solo-practice. Back in the 1982 to 1989 era, I did a lot of practice. I directed VCU Department of Psychology's training clinic for Counseling Psychology, the MidLife Counseling Center. We had a clientele of community folks. The sign was in front of our building, and quite a few psychotic folks lived in the park cattycorner from our building. They walked into my office almost daily. I had to hospitalize many and saw more psychopathology then than even when I was in the Navy. (I'm not sure, but perhaps Facebook has now surpassed that experience.)

I supervised two assistant directors and four doctoral students' practicum psychotherapy. That got me a single course release, as did being clinic

director—reducing my load to 2-2. And as part of my private practice, I served as clinical director and supervisor for a general Christian counseling agency and a secular rehabilitation counseling agency. (One winter day, one of the rehab clients tried to pass off a urine sample that was about 33 degrees Fahrenheit as a fresh sample. Hey, I was naive in those days, but not *that* naive.)

In 1988, managed care came into Virginia—at least into my practice—and the paper work in those early days was prohibitive. So, in 1989, after one year of treatment plans every four sessions, I was asked to be director of undergraduate studies in psychology. (We have about 1600 majors, so that promised to keep me off the streets and out of trouble.) I jumped at the job. I closed my private practice to focus on research, teaching, and administration.

I Actually Did Have a Research Career—Really!

My counseling and psychotherapy experiences have served me well. Besides publishing a fair amount of basic research over the years in Social Psych, Personality Psychology, Developmental Psychology, Health Psychology, Psychology of Religion, and more basic BioPsychology, I never got over my desire to help people through intervening with psychological interventions. I still seem to publish more basic psychology than applied psychology, but I also still have a heart for interventions to promote forgiveness, humility, and other virtues, religiously accommodated treatments, and the hope-focused couple approach.

About 1983 or 1984, I was bitten by the forgiveness bug. I was supervising Don Danser, an advanced doctoral student by then, and he was doing couple therapy, which was the type of therapy I found I liked best. I also love psychoeducational groups as well. That particular day, I asked Don why a particular couple wasn't getting better. (In my arrogance, I couldn't understand how they could be using the Hope-Focused Couple Approach and not getting better. Don, the soul of tact, said, "I don't know. They can do all of the conflict resolution, communication, and intimacy development that the Hope-Focused Approach teaches…" (Thank you, Don, that was the correct answer. You shall receive your PhD–eventually.) "…But they just hate each other. They have all of these grudges that they have nursed for 20 years."

"Well," I said, "then we need to create an intervention to help them forgive each other."

Don swallowed his bubble gum (or would have if he'd had any bubble gum). Those days were not all that welcoming to Religion and Spirituality (R/S)—even in therapy. (I can almost hear shocked gasps emitted by readers.) Forgiveness, even though we were working with a secular couple in a secular counseling venue, was largely considered religious. So, Don's response was, "Can we do that in a state university?"

"Sure we can. I'm the supervisor." A pause. "We won't tell anyone."

So, Don and I sat there in a supervision hour and developed a forgiveness "intervention." In the next session we planned to ask (and by "we" I mean Don) whether the partners might think that forgiveness was an issue in their relationship. This really invited troubled couples to think, Sure!! HE (SHE) needs forgiveness for all the things he's (she's) done." So we expected hearty agreement. Then, in the old switch-o-change-o of couples therapy, we (and we're talking Don—much too dangerous for a supervisor to do this) would say the switch. "Okay, so this week, I'd like each of you to think of the many ways you've hurt and disappointed your partner over the years. Next week we'll allow you to confess those and seek forgiveness for them."

The intervention worked marvelously, and I taught it to Fred DiBlasio, a PhD in Clinical Social Work colleague whose Christian counseling agency I was supervising. Finally, in 1989, after trying it in my own practice with many clients and having Fred and numerous supervisees try it, I

wrote it down in an article (Worthington & DiBlasio, 1990). Getting it published was another adventure in those days—the *Journal of Marital and Family Therapy* liked it, but wanted us to remove the offensive religious language—"forgiveness"—and call it "forgetting." We demurred. They rejected. *Psychotherapy* published it in 1990—with the offensive F-word (in the title no less).

Let the Research on Forgiveness Begin

Mike McCullough entered our doctoral program in the fall of 1990, just as the Worthington and DiBlasio article came out in August 1990. He named forgiveness as his drug of research choice. He was most interested in the social psychology of forgiveness. However, we did publish a one-hour intervention to promote a decision to forgive and later an 8-hour intervention to promote emotional forgiveness. Right after Mike, Steve Sandage also was interested in interventions, and we published a group treatment (and eventually the book, *Forgiveness and Spirituality in Psychotherapy: A Relational Approach*; Worthington & Sandage, 2016). Jen Ripley followed shortly after, and Jen was interested in the Hope-Focused Couple Approach (see www.hopecouples.com) and we integrated much emphasis on forgiveness and reconciliation in that approach.

Sneaking through the Back Door into Public Health

Our current public health-related work. The intervention research on forgiveness, using the REACH Forgiveness model, has caught on, and over 30 randomized controlled trials have been published at this point. In fact, we are conducting a multinational randomized controlled trial funded by the Templeton World Charity Foundation (TWCF). Man Yee Ho from Hong Kong, is PI. Tyler VanderWeele (Harvard) and Maya Mathur (Stanford) and I are supportive characters testing REACH Forgiveness—in a two-hour workbook format—in Hong Kong, Indonesia, Ukraine (two sites), Colombia, and South Africa. If we succeed at the project, several things will happen. (1) About as many participants will go through the REACH Forgiveness—see Worthington and Sandage (2016)—workbook trials (3000 or more) as have participated in forgiveness interventions of any kind by any investigator since the study of forgiveness began. (2) The workbooks have been translated, and they will be publicly available in English, Spanish, Mandarin, Cantonese, Russian, Ukrainian, and Indonesian. They will be available to about two-thirds of the world's population without cost in their native language. (3) Because forgiveness has been found to be directly related to better physical health, mental health, relationships, and spirituality (and mental health, relationships, and spirituality all have been found to have having indirect impacts on physical health), this is a large-scale public health study.

Where did the public health and religion work start germinating? But, the TWCF grant has another goal, and it is even more directly related to public health. We test in each of those six locations, a public awareness-raising campaign. Awareness-raising campaigns about forgiveness to help an entire community have been tested several times. For example, a forgiveness awareness campaign was first tried and found to be helpful at John Brown University (Lampton et al., 2005) and later at Asbury University (Stratton et al., 2008). In 2008, I applied to Fetzer Institute, which had a larger grant-making presence then than now, to fund a project on a public health campaign to promote forgiveness in Christian colleges and universities, and it ran 2009-2011. Eight Christian colleges (and one secular state university) participated. The idea was to flood a community with messages about the importance of forgiveness and the availability of interventions to promote forgiveness. The impact on health was assessed. Our strongest (methodologically) public health intervention was at Luther College (funded under the Fetzer initiative), and the result was published in *The Journal of Positive Psychology* (Griffin et al., 2019). Building on these experiences, the TWCF-funded project's public-awareness campaign has three goals: (a) to define forgiveness as two types—a decision to treat the offender better and an emotional transformation;

(b) to raise awareness of the physical health, mental health, relationship, and spiritual benefits of forgiveness; and (c) to show that no-cost interventions are publicly available (see www.EvWorthington-forgiveness.com).

These efforts on forgiveness research have eased me in the back door of public health research. In 1996, my mother was murdered (for the account of my experiences with coping with the grief and forgiving the young man who killed her, see Worthington, 2003). That experience unsettled me and set me searching for meaning, and in the next six months, I arrived at a new mission in life: to do all I can to promote forgiveness in every willing heart, home, and homeland. So, the homeland target has been a large one. It has led to lots of efforts—like going to Singapore and speaking to all of the Family Court justices and all of the police who were not actively out on duty. It also has led to many consultations with national organizations. It has led me to try to work with the Christian churches, not limited to any particular denomination, to help promote forgiveness with religious folks. It has led to studying forgiveness in other countries, including Ghana (using a Christian accommodated intervention), the Philippines (also using a Christian accommodated intervention), and India (using a secular intervention but with people who were largely Hindu adherents).

Incorporating Public Health into My Professional Identity—and Inviting You to Make It Part of Your Identity, If It Is Not Already

But it really was an invitation to speak at Harvard's School of Public Health by Tyler VanderWeele that got me thinking more broadly of the public health potential of forgiveness interventions. That was my formal introduction into public health circles.

I started this little reflection talking about standing around a bit awkwardly in the public health dance. Thankfully, that feeling didn't last long. The public health and religion community is a welcoming community, and perhaps readers of the newsletter who are not trained in public health can benefit by my experiences of being welcomed in. The people are warm and inviting, and most of my awkwardness has come from not being fully familiar with the research literature and statistical methods as I am becoming. To get current with the research findings, I purchased Doug Oman's (2018) fantastic review of the literature in the field, *Why Religion and Spirituality Matter for Public Health: Evidence, Implications, and Resources* (Cham, Switzerland: Springer International). Just perusing the contents makes me feel smarter. (Yes, I know that's an illusion or perhaps delusion.) Reading the chapters got me feeling up to speed on the content of the subfield of religion and spirituality in public health. I must admit, of course, that the stats border on a mystical experience for me. The stats used in public health are not the ones typically used in experimental or clinical psychological science. So I still have some moments in which I feel like a beginning grad student, reading and understanding the intro, method, and discussion of articles, but in the results, well, those things can sometimes call to mind the American favorite, Charles Schultz's comic-book character, Charlie Brown. Charlie Brown's response to his teacher, Miss Othmar, is like the results can sound to me: "Wah, wah, wah." But keeping up with the latest stats is always a challenge in any part of psychology, and public health, it seems, is no different. So, I'm working to become a back-door R/S-and-public-health contributor. But it might take a while. Meanwhile I can enjoy the welcoming demeanors of the colleagues I interact with and the new places we travel to, together.

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Religion and Public Health: Learning from the [Ancient] Past

Susan R. Holman[1]

Editors' Note: In addition to interviews with senior scholars and other features, the PHRS Bulletin includes personal essays written by field leaders and other key contributors. Here, Dr. Susan Holman describes her background as a historian of religion, providing numerous resources, tips and reflections on how religious history can contribute to the growing field of religion/spirituality and public health.

I grew up in a Protestant, working-class family that considered it a privilege to be able to live in one of Boston's wealthier suburbs. This "privilege" encompassed what we now call the social determinants of health: excellent public schools, easy public transportation, safe housing, clean water, good neighbors, and nearby medical facilities of world-class excellence. My parents' relative poverty, employment limits on "sick time," and daunting health insurance deductibles severely limited affordable health care access—with no dental insurance at all—but we got by. My parents' concern to see their children "succeed" meant that I felt pushed from an early age to study the sciences, even though I much preferred reading and creative writing—especially historical stories—from the time I could hold a pencil and open a book. Following undergraduate studies in nutrition and psychology with a biology minor, I was accepted into a rigorous dietetic internship/Master's program that included clinical, health communication, and public health rotations, at Tufts' Friedman School of Nutrition Science and Policy. My first job out of graduate school was in an urban community health center, non-stop counseling low-income families on maternal-child health, while writing my first serious book, a nutrition text for nursing students. Although I cared about health inequities and the human face of poverty, I was quickly bored—and soon burnt out—by the perpetual process of telling people what to eat. My escape reading on evenings and weekends was in religious history, soon diving into little-known texts about religious responses to poverty, illness, and hunger in Late Antiquity. Eventually I quit clinical work, took a part-time hospital job in medical writing and editing to pay the bills, and went back to graduate school to follow what was, I then knew, my real vocational passion, for scholarship and writing in religious history. Further graduate studies at Harvard Divinity School and my doctoral work at Brown focused on fourth-century Greek Christian sermons on poverty, hunger, and disease. The texts were largely unknown because theology scholars cared little for their focus on everyday social details, and health science readers ignored religious texts entirely, especially those in a foreign language.

Susan Holman

From the start, my interest in these narratives invited broader questions. For instance: How might these voices' obvious commonalities between past and present social injustices relate to faith-based responses to health and welfare in today's world? Where did this ancient history continue to influence health beliefs and service practices into the present—for better and for worse? While modern medicine may all too often frown at or scorn any mention of religion in the health sciences, how might the study of such religious history contribute *positively* to modern public and "global" health concerns? And how do we respect the "voices" of ancient texts and cultures in a way that avoids

uncritical, anachronistic, or purely instrumental "use" or "application"? Narratives that were written in the distant past but are still read today, that is, never offer a neat ethical Bandaid but are rather a complex and even dynamic construct of intersecting relationships. This is especially true of ancient narratives rooted in faith traditions that continue to apply such belief structures to modern health care responses within family and global or community services. Providers need to be aware of such histories and influences. Goethe reportedly wrote that whoever "cannot draw from 3000 years is living hand to mouth" (as quoted in Gaarder, 1994, v, p. 161). And as I continued for more than twenty years after graduate school to work directly with health care providers, it seemed clear that most were not able to draw from the rich well of history that Goethe described as essential. Despite their admirable value for addressing "resource-poor" settings in medicine and public health, that is, most health efforts (with rare exceptions) seemed chronically time-crunched, fixated on the latest new and cutting-edge evidence-based data, while perhaps oblivious to the many underlying impacts of religion and history on the very same cultures and social practices that effective health care delivery often sought to "improve."

Happily this disciplinary blindness has lifted, at least in part, over the past decade. Both medicine and public health today tend to more openly recognize the need to reckon, seriously, with issues of religion and spirituality (R/S). This new awareness now shapes efforts, for instance, not just in traditional bioethics and psychiatry, but also in global health, narrative medicine, clinical subdisciplines such as oncology care, in the role of health care in human flourishing, and in the medical humanities. But those who understand why R/S matters for health and medicine today are often still puzzled or skeptical about the relevance of religious history.

While my work focuses most on history shaped across the Christian tradition, there is much overlap between early Christian, Rabbinic, and early Muslim texts (where we have them) on medicine, social welfare, and health care services in Late Antiquity. Indeed, a virtual subfield has emerged of scholars who examine religion, medicine, disabilities, and health in the ancient world, and many of these scholars deliberately engage past with present. What follows in this essay is a select summary of common thematic connections that enhance our understanding and practice of public and global health today. I then highlight three common "missteps" in the use of ancient sources in public health scholarship, and offer a few concluding thoughts.

Common Connections

Western religious traditions from Late Antiquity—roughly the period between 100 and 800 C.E. in ancient Graeco-Roman, Persian, and early Islamic cultures across Europe, the Middle East, and northern Africa—inform how we got where we are today. These traditions, preserved and perpetuated in "folk" beliefs, theological statements, and religious practices continue to shape individual and community choices that directly impact both the social determinants of health and the social determinants of public health responses. While we tend to think of medicine and public health as two distinct areas of study, medical historians (e.g., Ferngren, 2014; van der Eijk, 2005) make it clear that ancient writers viewed environment, society, and population dynamics as key factors in what went on (and went wrong) in individual bodies. Thus the history of medicine in the ancient world inevitably overlaps with a history of public health. Health science students and scholars interested in how the ancient past shapes the present must pay as much attention to ancient *medicine* as to standard *public health* topics such as population health, environment, climate, social crises, health equity, and epidemiology. Within the public health literature itself, Nancy Krieger (2011, pp. 42-57) offers an accessible starting point for understanding some of the basic terms and ideas relevant to religion in public health history.

Disciplinary periodicals in public health may also include a nod to the past. The *American Journal of*

Public Health, for instance, invites history essays or short "Voices from the Past" for one such History section.[2] While not focused explicitly on R/S themes, this section represents a good-faith effort at meaningfully engaging history to inform modern practice. In health equity dialogue and action, themes of liberation theology and the history of human rights (including but not limited to controversial topics such as sexual and reproductive rights), further shape health narratives (e.g., Farmer & Gutiérrez, 2013; Holman 2015, pp. 83-122; Reed, 2007; Yamin, 2015, 2020).

Beyond disciplinary publications in health science, scholarly resources from across the arts and humanities connect a broad range of issues directly pertinent to modern public health. These include, to name just a few: the role of environment, epidemiology, religious culture, politics, and climate change in the ancient Graeco-Roman world (e.g, Green, 2017; Harper, 2018; Stathakopoulos, 2004), therapeutic rhetoric pertinent to infectious disease and "contagion" (Buell 2014; Holman, 1999; Mayer, 2015a, 2015b, 2018; Miller and Nesbitt, 2014), mental health related to the religious "voice" (Cook, 2019), the emergence and development of hospitals and health care systems in the Western world (Anderson, 2012; Crislip, 2005; Henderson, Horden & Pastore 2007; Horden, 2005, forthcoming; Marx-Wolf, 2018; Miller & Nesbitt, 2014; Nutton, 1977, 2013), Rabbinic and Islamic health care (Balberg, 2014, 2015; Ragab, 2015, 2018; Shinnar 2019); nutrition and the body (Penniman, 2017), disability and medicine (Laes, 2019; Watts-Belser, 2017), philanthropy and human flourishing (Rhee, 2018), and "folk" or popular medicine (de Bruyn, 2017; Harris, 2016; Mercier, 1997).

Interpretive Challenges

One serious challenge to reading across disciplines, however, is that of interpreting sources fairly and responsibly. This is a particular challenge in connecting past and present texts and "evidence" on health. To help scholars begin to understand and address this challenge, Heidi Marx, a specialist in ancient religious philosophies and the history of medicine, and Kristi Upson-Saia, who team-teaches a course on the bioethics, economics, and history of medicine, as well as public health epidemiology, published an essay on "The State of the Question: Religion, Medicine, Disability, and Health in Late Antiquity" (Marx-Wolf and Upson-Saia, 2015). The authors are co-founders of the international working group on Religion, Medicine, Disability, and Health in Late Antiquity[3] and co-authors of a forthcoming sourcebook on ancient medicine to include sources useful in public health education (Upson-Saia, Marx-Wolf, & Secord, forthcoming). While "The State of the Question" speaks most directly to scholars in the study of Late Antiquity, its discussion on three potential "methodological missteps" is relevant to health science readers as well. These three "missteps," described below, present interpretive challenges that commonly plague anyone who wishes to responsibly connect contemporary issues with health and religion across history.

The first potential misstep, the authors suggest (p. 266), is when we impose modern interpretations on ancient understandings about illness, disease, impairment, and disability. For example, illness in antiquity represented communal and systemic 'disharmony' rather than the modern physiologic understanding of pathogenic "attacks." Diseases explained by ancient authors in terms of bodily humors and qualities of air, water, and environment may at times appear to evoke similarities with modern ideas. In fact, we must always keep in mind that such explanations are based on a very different set of assumptions, expressing a rhetoric or viewpoint on the body quite unlike twenty-first century allopathic medicine and evidence-based public health. If we fail to recognize these differences, such misunderstandings "can obfuscate our access" (p. 266) to the physical impairments or illnesses described by the original authors. Further, imposing modern taxonomies of disease and embodiment risks missing the diagnostic social

variables that may have been more relevant to the ancient cultures.

A second potential misstep is the imposition of modern disciplinary boundaries. Ancient medical and health-related texts rarely separated the individual body from its social, religious/spiritual, and environmental context. Indeed, "'professional' medicine was, from its earliest moments…interwoven with religion and philosophy." (p. 269). To silo such studies within our modern boundaries risks misinterpreting the sources (or missing them completely).

A third potential misstep, these authors suggest, is "overlooking lived experience," that is, treating ancient illness narratives as merely 'fictions' or representations. To assume that past stories are nothing *more* than fictive constructs risks missing the "everyday lives and experiences" of the sick, disabled, dying, and healing bodies and social relationships in antiquity. Even if a distant time is no longer available for certain strictly empirical measures, recent studies in historical anthropology and bioarcheaology illustrate how the past does leave us substantial "evidence-based" data on the effect of lived experience, in bones, teeth, DNA, burial practices, and the archaeological remains of urban water and sanitation management (e.g., Gregoricka, Sheridan & Schirtzinger, 2017; Kemp, 2013; Killgrove, 2018; Koloski-Ostrow, 2017; Lewis, 2010; Lockau et al, 2019; Prowse, 2018; Robb et. al., 2019; Rohnberger and Lewis, 2017). Thus historical sources indeed bear genuinely human data that, with careful reading, sometimes identify issues from the past that merit ongoing discussion today.

Conclusions

The interconnecting fields of R/S, "ancient" history, and public health today are marked by ongoing lively thematic dialogues rather than static conclusions. This essay introduces the dialogue and highlights some key points vital for responsible interpretive consideration given the current state of scholarship at this intersection. Such interdisciplinary dialogue is possible and, I would argue, necessary, because social determinants of health, including public health, are similar and similarly relevant across the centuries, and often shaped by religion and spiritual traditions that are rooted in the distant past. Taking time in public health to think about the history of religious texts, religious spaces (whether rhetorically constructed or literal built space), and ideas that have shaped faith and health traditions and communities—can help students, scholars, and practitioners to build and appreciate constructively critical thinking on health risks and challenges still relevant today.

When we understand and appreciate such differences between past and present, we may also open ourselves to cultural sensitivities that respect different expressions and understandings of body and illness today. The effort to see the past in this way may help train diagnostic and therapeutic skills to better engage diversities among disciplinary conversation partners, comparable, perhaps to the way art appreciation is used with medical students to improve clinical diagnostics (Miller, Grohe, Khoshbin & Katz, 2013). Yet we must always keep in mind that past and modern cultures will never exactly align, despite the temptation to conflate apparent similarities with the global cross-border dynamics of our modern world today.

Where ancient sources manifest or illustrate the "dark side" of PHRS—for example, religious discrimination, abuse, sexual and gender bias, ethnic oppression, and health-related human rights violations—critical thinking about R/S and public health across history can keep us honest, open to our own issues and implicit bias in the human journey and its everyday choices about body and society, open to ways to address such injustices, and mindful of our own health as it touches on the health of those around us. Thinking "outside the box" on R/S and public health across history may enable us to push back on religious and scientific boundaries we might encounter that otherwise perpetuate unhelpful stereotypes through ministry, health, and social service efforts. While readers in the health sciences should never uncritically "hunt

the present in the past" (Pormann and Savage-Smith, 2007, 4), we can recognize how, in health care and faith-based responses to hunger and disease around the world today, the past still haunts and shapes the present. Carefully perceiving and listening to the voices of conversation partners from another time may equip us to shape new public health choices that learn from their mistakes—and their wisdom.

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[2]^Guidelines for contributor to the *AJPH* history section are available at http://ajph.aphapublications.org/userimages/ContentEditor/1432646399120/authorinstructions.pdf.

[3]^ ReMeDHe. https://remedhe.com.

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Resources & Updates: Spring/Summer 2020

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

- Wikipedia page: Impact of the COVID-19 pandemic on religion
- World Health Organization's Practical considerations and recommendations for religious leaders and faith-based communities in the context of COVID-19.
- CDC webpage for community and faith-based organizations
- Emory University Interfaith Health Program COVID-19 Resources for Faith Communities
- Emory University Interfaith Health Program COVID-19 Resources for Low and Middle Income Countries
- Joint Learning Initiative for Faith and Local Communities COVID-19 Resource Page
- Humanitarian Disaster Institute, COVID-19 Summit
- Christian Connections for International Health COVID-19 resources & online forum
- JLI-CCIH Report on global faith-based responses to COVID-19
- Berkley Center for Religion, Peace, and World Affairs, Joint Leaning Initiative on Faith and Local Communities, and World Faiths Development Dialogue joint google doc of Faith and COVID-19 resources
- Religions for Peace dialogue between religious leaders and scholars on the intersectional nature of "Leadership" in and beyond a time of pandemic
- Religions for peace multi-religious COVID-19 Hub
- Special Issue: Christian Journal for Global Health, COVID-19 special issue
- Special Issue: Journal of Religion and Health, Religion and Health During the COVID-19 Pandemic

New Research & Materials

- November 2019: The Role of Religion for Mindfulness-Based Interventions: Implications for Dissemination and Implementation (Palitsky and Kaplan), *Mindfulness*
- February 2020: Private Religion/Spirituality, Self-Rated Health, and Mental Health Among US South Asians (Kent et al.), *Quality of Life Research*
- February 2020: Does spirituality or religion positively affect mental health? Meta-analysis of longitudinal studies (Garssen et al.), *International Journal for the Psychology of Religion*
- February 2020: The role of Hope in subsequent health and well-being for older adults: An outcome-wide longitudinal approach (Long et al.), *Global Epidemiology*
- March 2020: Religion, Spirituality, and Health: New Considerations for Epidemiology (Ransome), *American Journal of Epidemiology*
- April 2020: Handbook of Spirituality, Religion, and Mental Health, 2nd Edition (Rosmarin and Koenig), Academic Press
- May 2020: Religious Service Attendance and Deaths Related to Drugs, Alcohol, and Suicide Among US Health Care Professionals (Chen et al.), *Jama Psychiatry*

Upcoming Conferences

- Currently all conferences are cancelled or postponed. We will update the conference section in the Fall 2020 Issue.