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Editors' Introduction: Fall 2020 Issue #3

Welcome to the third issue of the *Public Health, Religion and Spirituality Bulletin* (*PHRS Bulletin*), published by the Public Health Religion and Spirituality Network (PHRS Network). For all of us, 2020 has been a year of the unexpected – and the ongoing! In the months since the pandemic began, so much of our lives have turned "virtual" with more time than ever spent in front of our computers and screens. We hope that this issue – whether you read it online or print out the PDF (or HTML) and read it on good old-fashioned paper – proves a bright spot that is both engaging and enriching for your work at the intersections of religion, spirituality, and public health.

This issue begins with an interview with Neal Krause, a sociologist and leading researcher of religion, spirituality and public health. As a bonus, we also offer a video recording of the interview to allow you to get a better flavor of Neal's wonderful openness and insight, as well as our stellar team of interviewers. Next is an article by Doug Oman that provides a timely overview of research related to COVID-19, religion/spirituality, and public health. To our knowledge, it is perhaps the first significant *global* overview with attention to empirical findings, policy reports, and conceptual publications. Blake Kent authors an article that delivers an accessible overview of his and his colleagues' work exploring R/S factors and health among US South Asian populations. Next, is an article authored by early career professional Caitlyn Gudmundsen describing the way her upbringing in a faith-based environment coupled with her graduate training in religion and public health catalyzed a bridge building career as the Director of Strategic Initiatives at Lutheran Services in America. Following this, Kelsey White and George Fitchett's article gives readers an overview of their groundbreaking work developing a training program for health care chaplains through the School of Public Health at University of Illinois, Chicago, which we hope inspires others to consider equally innovative cross-disciplinary work. This issue closes with our resource article highlighting new empirical work, upcoming conferences, recent conference proceedings, and COVID-19 related resources.

The *PHRS network* was officially launched in the Spring of 2019, and the present issue marks the first full year of the *PHRS Bulletin*. In our annual board meeting this September, we reflected on what we have learned over the past 18 months and how we might improve and build the network going forward. To do so, of course, requires us to hear from YOU, our readers, as our efforts will not bear the intended fruit if we are not building a network that draws together and strengthens the collective work of those engaging with religion, spirituality, and public health.

To this end, would you spend five minutes or less completing this brief **reader's survey (link)?** We know time is limited and that goodwill is pulled in a variety of directions… but we ask anyway (☺) and thank you in advance for your generosity.

Finally, we are pleased to introduce Angela Monahan as our new junior editor. Angela is a recent public health graduate from UC Berkeley where she participated in a traineeship on religion, spirituality, and public health directed by Doug Oman. She is currently working from Washington D.C. as an Association of Schools and Programs of Public Health (ASPPH) and Centers for Disease Control (CDC) fellow and has been an integral part of conducting interviews with leading scholars for all three issues of the *PHRS Bulletin.* We are excited to have Angela join our editorial team!

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

Sincerely,
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Interview with Dr. Neal Krause

Angela Monahan,[1] Andrea Jacobo,[2] and Angela-Maithy Nguyen[3]

Editors' Note: We are pleased to present the third 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 **Neal Krause, PhD**, Professor Emeritus of Health Behavior & Health Education at the University of Michigan, and Marshall H. Becker Collegiate Professor of Public Health. Dr. Krause's work on stress and the resources that people use to cope with stress – including especially religious resources – have been a huge contribution to the field of religion, spirituality, and public health. Identified by the Institute for Scientific Information as one of the 250 most frequently cited social scientists, Dr. Krause has published 350 refereed journal articles as well as 40 book chapters and, to date, two books; he was also chair of the working group that produced the widely used set of recommended measures, *Multidimensional Measurement of Religiousness/ Spirituality for Use in Health Research* (Fetzer Institute & National Institute of Aging, 1999; 2003). Dr. Krause was interviewed for the *PHRS Bulletin* by graduate students Andrea Jacobo 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 Monahan: Fairly early in your career, since 1989, you've studied religious involvement. What motivated you to start studying religion and how did that influence your other interests?

Neal Krause: I was a big stress guy up until 1989 – that was my thing. When I did my first community survey, it was on stress and health in older adults. I had nothing on religion, and every time the interviewers came back to my office, they said, "there's another one that said 'I rely on religion'". I remember thinking I didn't want to go there, you know? Those people that do that are weird. They have a personal agenda to sell and on and on; But what can I say? I'm one of the geeks now and I got into it for that. I avoided it for a long time and then it found me.

I wrote my first paper on religion in 1989 and it was a secondary data analysis (Krause & Van Tran, 1989). I get a call from the National Institutes of Health and they tell me they're having a meeting on religion and health, and that I was an expert on subject. I said, "Wait, wait, wait. I've written one paper; I'm not an expert." "Oh, but you should come" [they responded], so, I went and there was about three hundred people. They said, "we're going to break out sessions in the afternoon and one of the breakout sessions is going to be on how to measure religion"; And they told me I was going to chair it. I did that and I didn't really know what it was all about. Probably two years after, I chaired the group and we put together measures that could be inserted in epidemiologic surveys on religion. That's what got me into it and then I just got fascinated by it. It's such an integral part of life. My guess is you get older and you start thinking about those kinds of things.

Neal Krause

Angela Nguyen: Speaking of when you chaired the group that put together that influential and highly cited book of measures [Fetzer Institute & National Institute of Aging, 1999, *Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research*] — how would you describe your experience working with the group, especially your role as chair? Were you satisfied with what you produced, and did it have the impact you were hoping for?

What's the shortest list in the world? … Disciplines that aren't doing something with religion. – Neal Krause

Neal Krause: I participated in that book project because I really believe in the social basis of religion. I think you can't talk about religion without talking about people plural. I know it's not that way in all faiths, but certainly in the United States. It's all about congregations and relationships that people develop within them. I felt that wasn't given any major attention. People kind of asked a few questions about it, but there was nothing serious being done. I used that initial point of departure for getting into stuff that I had done just prior to that. It's funny; I wrote a grant to the National Institute on Aging, saying that I really wanted to study religion, but I don't know what it is. I wanted to do three years of qualitative work, develop good measures from that, and then get into the research. I remember my project officer said, "it'll never be funded. They don't fund small-scale development projects". I didn't care because it was what I needed, and guess what? It got funded the first time through, and for three years I did amazing amounts of qualitative research, with focus groups, 113 in-depth interviews, and more. I actually developed a tight set of measures, many of which were social support. I wanted to pull it all together in one place and show that this is an area in the field of religion and health that has been left out. I wanted to see if I could get that out there on the stage a little more clearly, and if you provide people with measures of the things you're talking about, you can do it. I can just say "don't just talk about social support, here are questions you can use to measure it".

And so, in this funded research project, I went through every dimension of the major social relationships in the church and had measures for each one, and theoretically, why they're relevant for health. I wrote a book about it (Krause, 2008). It was fun; I'd never written a book before because, you know, public health doesn't like books – it's all about peer reviewed articles. I wrote that book and now I'm writing another. When you write a book, it's really amazing. You have a lot more room. When you first start writing a book, you're a deer in the headlights. "I have to fill 300 pages, what am I going to say?", but it fills up fast enough.

Angela Nguyen: I like your perspective on the process of writing a book versus writing an empirical paper. Depending on what journal you're submitting to, there's so much focus on methodology and you don't really get to delve into the conceptual frameworks of why you're doing the study. You mentioned you're writing a book. Are you able to share about that?

Neal Krause: This new book is really different. I told my wife that at this stage in my career, this is my Sergeant Pepper's. When the Beatles did Sergeant Pepper's, it was so different. It was unique from start to finish and it blew the whole music industry away. I'm writing all in the first person – I want the readers to feel who I am. I want them to look beyond the words to the man that wrote them. There are three things I want to do. First, I want to tell you how I actually

practice my craft, warts and all; About the dead ends, the times I was wrong, the things that I didn't understand, and how I even reversed my position at some points, only because after much deeper thought I could arrive at a better thinking. The second thing is where I'm going next, which is kind of built around communities of faith. There's good theological and sociological research that says something unique happens when people get together in a church. The whole becomes larger than the sum of the parts. People stop thinking about 'I' and start thinking about 'we' – there's something almost mystical at that level. There are two different sources: one is a man named Dietrich Bonhoeffer – a pastor who was hung by the Nazis because he was involved in the plot to try to assassinate Hitler. He wrote a lot about this and Émile Durkheim writes the same thing. I thought we really have to get down to it and understand this. In this book, I have a chapter that lays out all the different things that a community of faith is likely to involve, and then this mystical thing that I can't really get my fingers on yet. I call for a very detailed qualitative study to find out, just like I did way back in the 80s. The third thing I'm doing with this book is addressing some very fundamental problems with latent variable modeling. That's the book; I've been offered a contract by one press and I'm waiting on another. The peer reviews have been amazing. They're just lovely and saying, "nobody but you could have written this book". In a way, it's true because this is my swan song that I've worked on for all these decades and what I have learned. I like this book better than the first, and I think the reception has been better. I'm giving the book a shot, in between going to school and some of the other stuff.

Angela Nguyen: You're balancing a lot!

Neal Krause: We've also gotten re-funded to go back and do a mortality study for the Landmark Spirituality and Health Survey, a project I began in 2013 that surveyed a national sample of more than 3000 US adults. The literature on mortality and religion is largely focused on church attendance only and we have to pull it apart and find out what's really going on there. One time ago, I heard a colleague of mine say that these big grants are like getting hit with a golden brick – if anything can go wrong, it will, and stuff you couldn't imagine going wrong, will go wrong. They don't teach you this in graduate school. You learn it, God knows how.

Andrea Jacobo: Could you say a bit more about those grants and your experience conducting them? What are some of the lessons that future investigators can learn from you in this process?

Neal Krause: I learned grant writing on the bended knee of my good friend Jersey Liang, who was fabulous at getting money. It's important to find somebody that knows what they're doing. I recommend networking and postdoctoral fellowships. Find a good group of mentors that can really help you with stuff like this because that's how you learn. Students tend to think that they're done once they have their PhDs. Not quite; you're actually just getting started.

Andrea Jacobo: How would you compare the challenges faced by the religion and health field in the late 90s to the ones we face today, and what do you think were the major shifts and trends? From your experience, where are we going in the future with spirituality and religion?

Neal Krause: Well, a couple things. Back in the early 80s, there were untruths in the articles. Jeff Levin used to say the 'r word'; as soon as somebody sees the r word, religion, you're stuck. There was a lot of academic prejudice against it – they didn't think it was a real science. Once people got out there and started doing really decent work, it gradually began to change and religion found itself integrated. If you think about it, what's the shortest list in the world? The answer to that is disciplines that aren't doing something with religion. Think about it – medicine, nursing, public health, sociology, psychology, social work, humanities, and anthropology. All of these fields are doing it now and that's a good thing because what it shows is the versatility of religion.

Where do I think it's going in the future? We're getting more biomedical. There's this 'let's get accepted by the real doctors, and the way you do that is with biomarkers. When I did the Landmark Spirituality and Health Survey, we got a whole range of biomarkers and I wrote a number of papers on those. That was a brand-new world for me and a way of getting my feet wet. You can't argue with that stuff. When you say religion is related to lower levels of bad cholesterol, it's hard to turn that around and say higher levels of bad cholesterol make you less religious. It does not make any sense, so the direction of causality becomes more clear. You never prove it, but you sure get a lot closer. I think that's the direction of where the field is going.

Andrea Jacobo: Earlier you mentioned communities of faith. In Memphis, there's the Memphis Interfaith Coalition and they address the different determinants of health like education, economics, and social economic status. The work that comes out of their community of faith is fantastic and beautiful. How would you say that communities of faith are similar to communities of practice and how can we incorporate what we already know with communities of practice and coalitions, and integrate them with faith?

Neal Krause: A lot of people are actually already doing that. Many congregations have formal programs like for lowering blood pressure or nutrition. I think what we need to do is two things. One is seeing what is unique about doing these things in a church. Part of the answer to that is you can access individuals through the church easier than you can with other ways. The second thing is, we need to see what is unique about what we are doing. Can we go to the Elks club and offer the same services, or is there something special that's going on in communities of faith? I'm betting that something special is happening, but we have to find it.

You know sometimes, when there's nothing out there, you freak out and wonder what to do and where to start. I say, start anywhere, but above all else, just listen to your gut and heart. You're getting into this field because something about it has appealed to you at a pretty deep level. Start with what has brought you here and pursue it. See where it leads you, and it could be dead ends. When you put your CV together, you list all your papers accepted for publications. Why don't we list the ones that were rejected? Isn't that a more honest reflection of what it is that you're doing? I still get papers rejected all the time, but follow your heart.

Angela Nguyen: Could you say a bit more about the process of dealing with rejected papers? I think that's relevant to everyone. [*Editors' Note: See video of this interview for additional advice from Dr. Krause on topics such as grantwriting, publication, and rejection.*]

Harold Koenig once told me he got three papers rejected in the same day. He's one of the pillars of religion and health, and he's gotten three papers rejected in the same day. If we're really honest, we would put our rejected papers on our CVs and they would be a lot thicker. Babe Ruth had more strikeouts than home runs and no one talks about that, but they should. It tells you something about real life.

Another thing that's helpful; Ken Pargament – he's a good friend of mine – laughs at me because I actually have 35 different files that deal with 35 different issues reviewers have raised about my papers in the past. It all comes down to experience and I suggest that you save everything you get back. When you when you go through these things, save some of your responses and you'll use them again, because chances are, you'll see these things again.

Angela Nguyen: Your perspective has been very valuable, not only for this interview, but for all of us here. How do you think religion and spirituality can be better integrated into academia and into curriculum?

Neal Krause: It really depends on the flexibility in the school where you wind up. Unfortunately, a lot of the time when students first finish their PhD

and get their first tenure track job, they're given a lot of the equivalent to intro classes and don't have a whole lot of flexibility, at least initially. If you find yourself in a place that gives you that kind of flexibility, then do religion and health; but if you don't find yourself in that situation, I think you can still use it as examples in class. Try to extract the broadest possible principles from religion and health so that you say, "we're going to see social relationships that are good for health, but let's think about such social relationships in a particular context and see if that makes any difference". The principle is still the same: social relationships matter. We're just changing the venue a little to sneak it in that way. Then you can even raise questions about if there is anything unique about those social relationships.

Angela Nguyen: On the student side, what are our roles in making that push for integrated curriculum if we're not going to be teaching after?

Neal Krause: I think the way you do it then is through your research. It gets down to how to write the papers that you write, and part of the answer is talking about the so-what questions in your discussion sections on how and where your research applies and what you're going to do with it.

Angela Monahan: Out of all your findings on religion and health, what most surprised you?

Neal Krause: That's a tough question to answer because there is what surprised me, what I liked the best, and what I thought made the most difference to me. The one that I think made the most difference to me was that giving is better for your health than receiving. I've shown that now with about five different data sets and with different dependent variables; mortality being one of them. People that give have lower mortality risk than people who receive. It's really basic stuff but it's so cool. It's telling you about who you are, how we're put together, and what we should be doing with our lives – helping other people is not a bad thing. For me, that's a big deal because you think about practical applications. What do we know about volunteer work through the church? It's a good thing and good for health. Well, this is just another context for giving. I think that's the one that I liked the best and didn't expect to see it that consistently. One of the things that social and behavioral sciences is always dinged for is that we don't use an experimental design. One way you get around that is the importance of replication. We get not one but ten studies that show the same thing and that adds a lot of credibility to the work.In the end, empirical science is only going to take you so far. All it does is reflect back to you the quality of your own ideas.

Angela Monahan: Do you have any suggestions for students or young professionals that are beginning their careers in public health and might be interested in religion and health topics?

Neal Krause: I'd say one, don't be discouraged. Two, you're going to work harder than you ever thought possible, and the third thing I'll say something a bit different. I remember my students would say, "if I just finish my preliminaries, everything's going to be alright. If I just finish my dissertation, everything is going to be alright. If I just get a tenure track job, everything is going to be alright. If I just get tenured, everything is going to be alright. If I just make full professor, everything's going to be alright". It's never going to end. So, if that's the case, strive to be happy where you are, which I know is hard to do, especially in the middle of the tenure thing. That's an amazing experience and you just have to keep your eyes on the broader things.

Angela Monahan: Thank you so much. That was all our questions. This was such a great discussion with you.

Neal Krause: It was fun talking to you guys. I love talking to students; they're great! It's nice to meet you all. Religion and health is a small town, so who knows? If we ever actually have professional meetings anymore, I hope to bump into you guys some time there.

This interview with Dr. Neal Krause took place over Zoom on October 8, 2020. The transcript has been edited for clarity and brevity. In addition to the published transcript, a video of the interview has been provided. The video also includes a variety of additional suggestions from Dr. Krause for early career professionals for navigating the NIH grantwriting process, publishing articles, and dealing with rejection.

Link to video:
http://www.publichealthrs.org/v001/

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Covid-19 and Religion/Spirituality: A Global Review from a Public Health Perspective

Doug Oman[1]

The SARS-CoV-2 coronavirus has upended daily life worldwide, infecting tens of millions of people, causing more than a million deaths to date due to Covid-19 disease, and inflicting a massive but largely unmapped burden of long-term disability and lowered quality of life among survivors. Religion and spirituality are among the strongest motivators of human action. Can the field of public health, religion and spirituality shed any light on how we can best respond to the pandemic? This article offers a selective review.

By Fall 2020 as this article was finalized, many dozens of professional journal articles from more than 30 countries, primarily peer-reviewed, had already been published about religion, spirituality, and the pandemic. Of these, a dozen-plus *empirical* studies have examined religion/spirituality (R/S) in relation to the pandemic. Available publications have reported a wide range of views, events, and findings. The aim of this brief article is to give the reader an introductory feeling for this literature by highlighting responses to three overarching questions that emerge repeatedly in this literature: 1) Does religion reduce or exacerbate risk of contracting COVID-19 disease? 2) How are religious communities responding? 3) What's needed from health professionals in relation to religion/spirituality and COVID-19? The article concludes by inviting readers' thoughts on best next steps.

Q1: Does Religion Reduce or Exacerbate Risk of Contracting COVID-19?

At least three US-based empirical studies have investigated and reached divergent conclusions about whether R/S engagement reduces or exacerbates risk behaviors for infection with SARS-CoV-2 and contracting Covid-19 disease (DeFranza et al., Lindow, 2020; Hill et al., 2020; Perry et al., 2020). These three studies employed widely varying research designs. Two were conducted at a collective ("ecological") level. They investigated whether US states and metropolitan areas that are more religious had engaged, early in the pandemic, in stronger protective behaviors. More specifically, did they engage in stronger social distancing behaviors? As a proxy for collective engagement in social distancing behaviors, both of these studies analyzed total aggregate *physical* mobility, measured via indicators of movement by automobiles or mobile phones. One study by DeFranza and colleagues (2020) appeared in *American Psychologist* and analyzed daily time series from the 53 largest US metropolitan areas, finding that areas with larger numbers of religious congregations were *less* adherent to shelter-in-place directives, after controlling for (aggregate level) education, unemployment, and poverty (data from March, 2020). Similarly, Hill and colleagues (2020) in *Journal of Religion and Health*, reported that US states with greater state-level religiosity measured by a six-item index exhibited *weaker* responses to stay-at-home orders, after adjusting for aggregate-level age, race, unemployment, and governor's political party (from February 24 to April 13). Such findings suggest that religious involvement may *exacerbate* risk of contracting Covid-19, at least in the United States.

In contrast, Perry and colleagues (2020) in *Journal for the Scientific Study of Religion* reported that a 3-item scale of religious commitment, comprised

of items for prayer frequency, religious importance, and service attendance, "was the leading predictor that Americans engaged in *more frequent* precautionary behaviors" (p. 405, emphasis added). These investigators used longitudinal panel data from a nationally representative sample of US adults (n=1255) from August 2019 to May 2020. However, in contrast to the protectiveness of religious commitment, Perry and colleagues (2020) found that COVID-19 risk behavior was *exacerbated* among respondents who reported higher levels of *Christian nationalism*, conceptualized as "an ideology that idealizes and advocates a fusion of American civic life with a particular type of Christian identity and culture" (p. 406). Furthermore, their 6-item measure of Christian nationalism "was the leading predictor that Americans engaged in incautious behavior like eating in restaurants, visiting family/friends, or gathering with 10+ persons (though not attending church), and was the second strongest predictor among Americans who took fewer precautions like wearing a mask or sanitizing/washing one's hands" (p. 405).

The interpretable yet divergent findings from these three studies underscore the importance of remembering that religion and spirituality are each multidimensional, and that whereas some dimensions may show salutary effects, others may show detrimental effects in specific contexts (e.g., Miller & Thoresen, 2003; Oman, 2018; see also Vermeer & Kregting, 2020 for a collective-level study in the Netherlands). In public health, where partnerships with faith-based organizations are often of great practical importance, such multivalent potentials of religion must be recognize and properly navigated: How can public health workers productively ally themselves with the salutary tendencies in religious communities and individuals, while mitigating or at least not exacerbating tendencies that are less healthy?

Q2: How are Religious Communities Worldwide Responding?

Jenny Trinitapoli and Alexander Weinreb's (2012) well-researched and thought-provoking book, *Religion and AIDS in Africa*, is to date perhaps the most in-depth study and consideration of religion in relation to a modern pandemic. Citing Horden (1999), Trinitapoli and Weinreb note that

> Historical accounts of the role of religion in times of plague, from the Roman era through the early modern period… all highlight the relevance of religion to… two types of 'management' epidemics demand:… to be understood, or managed conceptually; and… to be managed practically (p. 203).

In today's coronavirus pandemic, this dual conceptual/practical relevance of religion is illustrated by the wide range of topics addressed by recent journal articles on R/S and the pandemic. For example, several articles, some primarily conceptual, have addressed the possibilities and pitfalls of responding to the pandemic through so-called "virtual religion" (Parish, 2020, p. 6). One article by Jun (2020, p. 1) sought to address "controversial theological issues and reflect on them from an ecclesiological perspective [in relation to] ministries in virtual reality." Similarly, Parish (2020, p. 1) analyzed "different understandings of religion, church, and community in the period of a pandemic… [situating] the debates… in the context of historical precedent, personal experience, and theoretical approaches" (see also Pityana, 2020; VanderWeele & Long, 2020). Other published articles have profiled efforts to practice more socially distanced forms of religion by Parsis (Zoroastrians) in Pakistan (Engineer, 2020), Christians in the UK (Bryson et al., 2020), Christians in Italy (Madera, 2020), Christians elsewhere in Europe (Parish, 2020), and adherents to Afro-Brazilian religions in Brazil (Capponi et al., 2020).

A somewhat different emphasis on religion's practical roles in responding to the pandemic is evident in multiple articles reporting on cancellation of pilgrimages in Saudi Arabia (Ebrahim & Memish, 2020; Memish et al., 2020; Yezli & Khan, 2020). Furthermore, adherence to additional safety-promoting proclamations by Muslim leaders has been examined by an empirical study in Indonesia (Hanafi et al., 2020, about responses to a fatwa, n=1139). Some of these protective measures have been effective, but in other cases, populations have shown persistence in religious observance despite attempts by religious leaders to mandate reduced social contacts (e.g., Pabbajah et al., 2020, Indonesian Muslims). Some articles have discussed or documented the dangers of allowing large religious gatherings to proceed as usual, sometimes arguing that "Religious, social, and political leaders have to exhibit sagacity and adopt a pragmatic approach" (Quadri, 2020, p. 220; see also Badshah & Ullah, 2020).

Religious coping is the focus of several articles that have probed the intertwined conceptual and practical responses of religious individuals as they employ religious methods of coping in response to pandemic stresses. Empirical studies are available of pandemic religious coping by Jews in the USA (Pirutinsky et al., 2020, n=419), by Christians and Muslims in the United Arab Emirates (Thomas & Barbato, 2020, n=611), by African American Christians in the USA (Adams & Tyson, 2020, art-based inquiry with n=2), by Roman Catholic Christians in Poland (Kowalczyk et al., 2020, n=324), and by medical patients in India (Mishra et al., 2020, n=30). One study in Indonesia even investigated the role of Muslim religiosity in the survival of small businesses during the pandemic (Utomo, 2020, n=120).

Religious leaders are often under great stress, which is exacerbated by pandemics. Thus, Greene and colleagues (2020) made several recommendations for attending to the health of religious leaders, who may sometimes experience moral dilemmas in choosing between prescribed safety and traditional practice – among their recommendations were "Setting aside time to focus on spirituality" and that "It is important to acknowledge the moral conflicts that will likely emerge [from dilemmas in dealing with COVID-19]. Discussing them with colleagues and being prepared for some of the possible responses may facilitate coping and acceptance of distress" (p. S144).

Q3: What's Needed from Clinical and Public Health Professionals?

Last but not least, many articles have addressed how health professionals should understand or interact with religion in view of the pandemic. Many immediate practical responses have been advocated. For example, Koenig (2020, p. 776) described "seven simple ways that geriatric psychiatrists can help religious elders make use of their faith to relieve anxiety and help protect themselves and others during this COVID-19 pandemic." In the journal *Mindfulness*, Oman and colleagues (2020) reviewed randomized trial evidence on frequent repetition of a holy name or a mantram, a cross-culturally widespread spiritual practice extensively studied in the US Veterans Healthcare System, as holding "promise to benefit all major groups affected by the pandemic" including healthcare workers working with COVID-19 patients, patients and their families, and the general public. They suggested that such holy name/mantram repetition may be especially beneficial for COVID-19 patients experiencing respiratory distress, for whom conventional mindfulness approaches to stress management and resilience-building "may be ineffective or even contra-indicated" (p. 6).

On a more collective level, with an eye on population health, physicians at the Mayo Clinic systematically tabulated recommendations for how physicians could helpfully advise religious communities on responding to COVID-19 for Jews, Christians, and Muslims (Merry et al., 2020, p. 2 in pdf; each tradition was represented in the team of authors). Similarly, Bruce (2020, p. 425) argued for the importance of "African American churches, mosques, and temples as essential for an

immediate, comprehensive, and sustained response to the elevated risk for and spread of COVID-19 among African Americans."

More broadly, commentaries from countries as diverse as the US, Pakistan, and Somaliland have advocated for the value of partnerships between health professionals and community religious leaders, or have reported instructive experiences (Bentley et al., 2020; Galiatsatos et al., 2020; Hashmi et al., 2020; Hong & Handal, 2020; Thompkins et al., 2020). In Brazil, Kevern and colleagues (2020) reported on the history and pandemic response of a network of approximately 2500 volunteers, coordinated by the Catholic Church, that was for many years a recipient of much governmental support. Survey findings indicated that the model "may be exportable to other middle-income countries," with the network's "speedy and flexible response… to the coronavirus pandemic suggest[ing] that this type of NGO will have a role in response to future national crises" (p. 1).

On the other hand, also in Brazil, an entirely different and possibly complementary approach was described by Ribeiro and colleagues (2020, p. 1 in pdf), who recounted the well-received launch of a "Spiritual Care Hotline Project" in which trained psychiatrists and psychologists field requests for spiritually welcoming mental healthcare. These providers engage in structured interactions that encompass "(i) presentation, (ii) the main reason for calling, (iii) compassionate and affective listening, (iv) reading a short text with reflective content, and (v) prayer if the attendee feels comfortable," followed when appropriate by referrals.

Some commentators have warned that frontline health professionals may find themselves in excruciating dilemmas in conducting patient care, perhaps especially if healthcare systems are overwhelmed, putting them – like the religious leaders mentioned earlier – at risk for moral injury, understandable as "the lasting emotional, psychological, social, behavioral, and spiritual impact of actions that violate [one's] core moral values and behavioral expectations of self or others" (Shortland et al., 2020, p. S128; see also Borges et al., 2020). For spiritual support of healthcare professionals, Amiel and Ulitzur (2020, p. 840) described a program of three weekly sessions designed to understand stress and its sources and "adopt resilience strategies based on spiritual care tools" that included "deep listening", "connecting to personal resilience resources," and other methods.

New research is of course needed. Thus, writing in *Mental Health Religion & Culture*, Dein, Loewenthal, Lewis, and Pargament (2020) identified an agenda of seven issues that require future research, including studies of the comparative impact on mental health of virtual versus face-to-face religious activities; whether prejudice can be reduced in the context of the pandemic; and strategies for enhancing preventative behavior related to COVID-19 in religious groups. Various other agendas and suggestions for future research have also been offered – for example, based on a survey of 27 chaplaincy teams in the UK, Harrison and Scarle (2020) identified several pandemic-related chaplaincy issues requiring further inquiry, such as clarifying best practices regarding staff support.

Now What?

This year's professional literature on COVID-19 and religion/spirituality is by no means exhausted by the foregoing whirlwind tour of selected writings on these three overarching questions. Many other recent professional articles have addressed these questions, as well as other topics ranging from advocacy of inter-religious collaboration on COVID-19 to psychometrically analyzing religious items on COVID-19 anxiety screening tools (e.g., Corpuz, 2020; Lee, 2020). Our own PHRS Network is likewise compiling a set of COVID-related resources and links that build on the evidence cited above (see http://www.publichealthrs.org/resources/).

As the pandemic lingers and R/S-COVID-19 questions persist and multiply, much useful

background may be found in the pre-existing public health and religion/spirituality literature, which has carefully attended to numerous issues concerning religion/spirituality and infectious diseases (Oman & Riley, 2018), and has also wrestled with the "paradox" that religion generally correlates favorably with individual health measures, but that some dimensions may correlate with unhealthy collective norms or behaviors – as we noted has been occurring in the USA with COVID-19 (Oman & Nuru-Jeter, 2018, p. 115).

On a practical level, public health has given a great deal of attention to salutary partnerships between health professionals and religious communities (Epstein, 2018; Grant & Oman, 2018; Idler et al., 2019). The art of such partnering is profoundly local, yet successful partnerships can inspire efforts both near and far. The present literature search identified published articles on religion and COVID-19 from Australia, Bosnia, Brazil, China, Colombia, Ethiopia, India, Indonesia, Iran, Ireland, Israel, Italy, Japan, Kenya, Korea, Malaysia, Mexico, the Netherlands, Nigeria, Pakistan, Philippines, Poland, Portugal, Saudi Arabia, Somaliland, South Africa, Spain, Turkey, Uganda, Ukraine, the United Arab Emirates, the United Kingdom, the United States, and Vietnam. Translating such widespread interest into improved collaboration between religion and public health – one goal of the religion/spirituality and public health field, and of the *Public Health, Religion and Spirituality Bulletin* and Network – will boost global pandemic control efforts, benefiting everyone. We invite the *Bulletin*'s readers to share with us their ideas about how to foster such advances – send your thoughts to the editorial team c/o PHRScovid@publichealthrs.org, and/or take our Fall 2020 reader's survey (https://publichealthrs.org/s001/).

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What Have We Learned about Religion, Spirituality, and Health in the MASALA Study of U.S. South Asians?

Blake Victor Kent[1]

Editors' Note: Among many types of articles published in the PHRS Bulletin*, we include articles written by researchers who work at the intersection of religion, spirituality, and public health. These pieces are meant to provide an accessible overview of key findings, link readers to high-quality empirical work, and stimulate new ideas for research and collaboration. In this piece, Dr. Blake Victor Kent presents an overview of work by himself and others through a consortium exploring religion, health, and spirituality among South Asian populations in the United States.*

Thousands of studies have been conducted on religion/spirituality (R/S) and health, but in the U.S., many population samples often have substantial majorities that are Christian and white. Some ongoing cohort studies of minorities—like the Hispanic Community Health Study/Study of Latinos—include a sizeable number of R/S questions, but other racial and ethnic groups remain under examined. One such group is South Asians in the U.S., which constitute the fastest growing minority population while also representing a disproportionate burden of cardiovascular disease (CVD). To examine this pressing concern, the MASALA Study (Mediators of Atherosclerosis among South Asians Living in America) began ten years ago under the direction of Dr. Alka Kanaya, Professor of Medicine at the University of California, San Francisco.

Five years ago, MASALA partnered with Dr. Alexandra Shields, Associate Professor of Medicine at Harvard Medical School, becoming a member of the National Consortium on Stress, Spirituality, and Health. The Consortium, which includes several other ongoing cohort studies, developed an 82-item R/S questionnaire to distribute alongside MASALA's ongoing data collection efforts, opening up new avenues to examine R/S and health in this population. Prior to the current collaboration between MASALA and the Consortium, only a handful of studies had examined R/S and health among U.S. South Asians, including one on religious affiliation and obesity in MASALA and one on religiosity and negative affect in a Southeastern community sample (Bharmal et al., 2018; Diwan et al., 2004). While examinations of CVD are not yet complete, a team of Consortium researchers, including the present author, recently published three new papers, providing an important foundation for future work focused on the South Asian population (Kent et al., 2020; Stroope et al., 2020a, 2020b).

These studies assessed cross-sectional relationships between religion and spirituality and four outcomes: self-rated health, depressive symptoms, trait anxiety, and trait anger. Due to the large number of R/S items available, different sets of R/S variables were used in each study. One study focused on religious group involvement, assessing variables that included religious affiliation, religious attendance, participation in group prayer outside of religious services, giving and receiving love and support to and from fellow congregants, experiencing neglect by fellow congregants, and being criticized by fellow congregants (Stroope et al., 2020b). A second study investigated private religious and spiritual practices and beliefs, which included frequency of prayer, yoga practice, belief in God/the divine, gratitude, non-theistic daily spiritual experiences, theistic daily spiritual experiences, feelings of closeness to God/the divine, positive religious coping, negative religious coping, religious and spiritual

struggles, and feelings of hope in God/the divine (Kent et al., 2020). And a third short study looked at one variable: the degree to which people consider themselves to be religious or spiritual (Stroope et al., 2020a).

The first study on religious group involvement revealed several findings (Stroope et al., 2020b). In well-controlled models, Jains reported better self-rated health than Hindus and Muslims. Group prayer outside of religious services was associated with better self-rated health and mental health, along with lower anxiety and anger. Giving and receiving love and care in the congregation was linked to better self-rated and mental health, along with lower anxiety. Experience of criticism from congregation members was associated with higher anxiety and anger. Many of these results follow patterns identified in studies of other groups, largely indicating that participation in group religious practices is related to good health. Congregations provide places for friendship, acceptance, reinforcement of cultural norms and beliefs, and experiences of the transcendent. They also provide relationships that can lead to practical forms of material support, such as financial assistance in hard times or help with transportation.

This analysis also found religious service attendance was associated with higher levels of anxiety. One explanation that could be applied to this finding is the concept of "resource mobilization." In short, when people experience distress, they turn to sources of support to find help, and oftentimes that means religious resources. Thus, increased anxiety would hypothetically lead to increased attendance as a form of coping. This cross-sectional pattern may have emerged in this population since Hindus, which form the bulk of the sample, attend public worship events at a lower level than adherents to many other major traditions; Hinduism does not emphasize regular temple visitation. As a result, it's possible an uptick in attendance vis-à-vis anxiety was more readily identifiable in this population because of the lower levels of baseline attendance.

The second study on private religious beliefs and practices revealed a number of interesting findings (Kent et al., 2020). Yoga, gratitude, non-theistic spiritual experiences, closeness to God, and positive coping were associated with better self-rated health. Gratitude, non-theistic and theistic spiritual experiences, closeness to God, and positive coping were associated with better mental health; negative coping was associated with poorer mental health. Gratitude and non-theistic spiritual experiences were associated with less anxiety; negative coping and religious/spiritual struggles were associated with greater anxiety. Non-theistic spiritual experiences and gratitude were associated with less anger; negative coping and religious/spiritual struggles were associated with greater anger.

The most consistent of these variables was non-theistic daily spiritual experiences, which was beneficially associated with all four of the outcomes. This measure assesses the degree to which an individual lives in the moment and makes spiritual connections between themselves and the world around them. For example, one item states, "I experience a connection to all of life," and another reads "I am touched by the beauty of creation." Such "in-the-moment" presence appears strongly related to well-being, regardless of one's religious affiliation, and we have found that the measure may be well-suited for examining Dharmic faiths (i.e., Hinduism, Jainism, Sikhism, and Buddhism). There is some controversy over a potentially tautological association between non-theistic spiritual experiences and some mental health outcomes, leaving the door open for future research to explicitly examine these associations more closely (Koenig, 2008).

The third study examined the extent to which people characterized themselves as religious and/or spiritual (Stroope et al., 2020a). Interestingly, we found that being both "very" religious/spiritual or "not at all"

religious/spiritual were associated with lower levels of anxiety and higher levels of self-rated health, whereas those identifying as "slightly" or "moderately" religious/spiritual reported higher levels of anxiety and lower levels of self-rated health. This non-linear pattern has been seen in a small number of other studies and reveals the possibility that those who are very secure in their faith and those who have no faith at all experience similar levels of mental health (Galen et al., 2011). It is those who are uncertain of their faith—those who are "somewhere in the middle"— that tend to report worse health. This makes a good deal of intuitive sense, since experiences of doubt or frustration in one's faith are likely to be associated with various forms of ill health, as are experiences of being "out of sync" with family and friends that differ significantly on religious belief and practice. This dynamic between confidence in one's religious commitments (or lack of commitments) and better mental health is also worthy of ongoing investigation among a variety of religious traditions.

We participants in the partnership between the National Consortium on Psychosocial Stress, Spirituality, and Health and MASALA (along with other participating cohorts) are very hopeful that our collaboration will enrich our understanding of religion/spirituality and various psychosocial and clinical disease end points. We have only begun to examine these rich data and look forward to shedding more light on associations between R/S and health in the U.S. South Asian population in the coming years.

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Addressing Systemic Biases: A Recent Student Perspective on Religion and Public Health

Caitlyn Gudmundsen[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.*

As the daughter of two ordained Baptist ministers, my faith has been at the core of my daily life and identity since birth. My parents instilled in me the value of asking hard questions and studying my faith academically, and it was my religious upbringing that motivated me to pursue a career focused on service.


Caitlyn Gudmundsen

I found a love and interest for the field of public health during my undergraduate time at the College of William and Mary, and was drawn to holistic, empowering global health interventions. I was later introduced to the idea of "toxic charity" (Lupton, 2011), and began to reflect on my own role in church missions, grappling with the notion that, though well-intentioned, many of my faith-based efforts to help people likely did just the opposite, and reinforced systems of oppression, partly through their disproportionate emphasis on short-term relief rather than systemic improvement and empowerment. This epiphany led to my strong sense of calling to work at the intersection of religion and public health, and help foster connections between those two worlds to achieve better outcomes for those we aim to serve.

I completed a dual Master of Public Health and Master of Divinity at Emory University, and was inspired by the Emory faculty's commitment to interdisciplinary work. Before arriving at Emory, I had a narrow view of the intersection of religion and public health, but quickly learned it is much more complex and expansive than I could have imagined. My coursework broadened my thinking, and I learned to better speak the languages of both fields, a critical skill for working at the boundary of the disciplines.

While in graduate school at Emory, I had the opportunity to study at St. Paul's University in Limuru, Kenya. I had an incredible professor at St. Paul's named Esther Mombo, who is a thought leader on the impact of religion on HIV/AIDS. In many cases, religion has exacerbated the harm of the HIV/AIDS pandemic by shaming people living with the virus. However, religion is also a powerful way to make meaning and begin healing, and many African women theologians hold that the role of the church is to identify suffering in the world, name that suffering, and stand in solidarity with those who suffer. Standing in solidarity sometimes requires recognizing the pain religion has caused, and drawing on the strengths of faith to promote healing.

I am now serving as the Director of Strategic Initiatives at Lutheran Services in America, where I oversee grants that engage health and human service agencies with Lutheran heritage. Like me, the people I work with are motivated by their faith to serve vulnerable populations. The grant programs I oversee require participating agencies to disaggregate their program data by race, and

identify gaps in their programming that may exacerbate disparities.

I am finding that since George Floyd's murder, many faith-based organizations we work with are more motivated than ever to address systemic racism, and the health disparities it creates. I am also learning that well-intentioned antiracist efforts must be self-aware – we *must* recognize the baggage our faith-based work often carries in communities of color. Applying what I learned in Kenya from African female theologians: it is only when we unpack the historical harm of organized religion on marginalized communities that we can stand in solidarity with those impacted communities, and then draw upon the immense power of faith to foster physical healing, as well as societal healing.

As I seek to address and balance these powerful concerns and historical tensions, my education in public health and theology continues to provide a sturdy foundation.

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Developing Evidence-based Spiritual Care

Kelsey White[1] and George Fitchett[2]

Editors' Note: The PHRS Bulletin *regularly features articles on the teaching of religion, spirituality, and public health. Healthcare chaplaincy is one of the many primarily clinically oriented professions that is allied with public health and has overlapping concerns. This article profiles a training program for health care chaplains that was offered in the School of Public Health at University of Illinois, Chicago.*

Developing Evidence-based Spiritual Care: Some Background

For several decades chaplains have recognized the importance of research for better understanding and improving their work (Fitchett, 2002; Gleason, 2004; VandeCreek, 1988, 1992; Weaver et al., 2008). Specifically, research helps chaplains evaluate and improve their clinical care (O'Connor and Meakes, 1998). Additionally, it helps chaplains describe their work and its impact to healthcare colleagues who look to research to guide decisions (Handzo et al., 2014). Professional chaplaincy organizations have emphasized chaplains' abilities to demonstrate the integration of research within clinical care and prioritize evidence-based practices, regardless of setting, by including research literacy and collaboration among their core Standards of Practice (Association of Professional Chaplains, Standards of Practice for Professional Chaplains). More recently, demonstrating basic research literacy was added to the competencies required for chaplaincy Board Certification (Association for Professional Chaplains, BCCI Certification).

Despite these initiatives, for the most part healthcare chaplains remained primarily consumers of the growing research about religion and health and rarely contributors to it. A fundamental reason for this was that almost no chaplains had training in research. To address challenges posed by new needs and requirements for research capacity, one of the present authors (GF) and his colleagues launched the Transforming Chaplaincy project with funding from the John Templeton Foundation and, as you will see described below, created multiple avenues to expand research and research literacy within chaplaincy. To date, the Transforming Chaplaincy project has published a book to guide research literacy education, launched a resource website, guided research literacy efforts within chaplaincy education programs, and supported 17 Fellows through public health degrees. In the following sections we sketch the history of the Transforming Chaplaincy project, its ongoing impact on professional chaplaincy and chaplaincy research, and describe implications for the field of public health.

The Transforming Chaplaincy Project

The Transforming Chaplaincy project began in 2015 with grants from the John Templeton Foundation, and additional support from several professional chaplaincy organizations in the US. It was co-led by George Fitchett (Rush University Medical Center), who had trained in chaplaincy and epidemiology, and Wendy Cadge (Brandeis University), a sociologist of religion with an interest in chaplaincy (Cadge, 2013).

The central component of the initial phase of the Transforming Chaplaincy project was Research Fellowships that supported 17 board-certified chaplains to receive a master's degree from an accredited school of public health. The Fellows completed these degrees at schools of public health across the country, but they all completed a course titled Religion, Spirituality and Health: A Critical Examination, taught remotely through the

University of Illinois SPH. The course, described in a chapter in Doug Oman's book, *Why Religion and Spirituality Matter for Public Health*, provided an introduction to the literature about religion, spirituality and health (Lyndes, et al., 2018). Course activities included critical reading and presentations of published research and presentations by leading researchers in the field. The course challenged the Fellows to examine the mechanisms linking religion, spirituality, and health and provided a foundation for their future research.

Transforming Chaplaincy Fellows at 2019 capstone meeting

Additional Accomplishments of Transforming Chaplaincy 2015-2019 (Initial Phase)

In addition to the 17 Fellows, the initial phase of the project also supported a number of initiatives to expand research capacity among chaplains throughout the US and around the world. We provided research literacy curriculum development grants to 68 Clinical Pastoral Education residency programs, approximately one-third of the chaplaincy training programs in the U.S. With grant support, these programs provided research literacy education to over 850 chaplains in training plus 100 staff colleagues. In July 2018, we published *Evidence-Based Healthcare Chaplaincy: A Research Reader* (Fitchett, White & Lyndes, 2018), a book featuring 21 important chaplaincy research articles and currently in use as a text in chaplaincy research education around the world.

Additionally, we created an eight-week on-line introductory course to research for practicing chaplains. Of the 98 chaplains who have completed the course, many report that the course sessions helped them to understand and apply research findings to their clinical context. We also developed an experiential week-long Chaplain Research Summer Institute (CRSI) for practicing chaplains, with a total of 90 chaplains participating from 2017 through 2019.

Chaplains' increased engagement with research has moved beyond educational opportunities. They have also eagerly taken advantage of online resources and expanded collaboration efforts. In November 2017, the project launched a chaplaincy research and research education website (transformchaplaincy.org). The site became the go-to space for chaplains and others to learn about research literacy and research design, to network and find research collaborators, and to build resources for the teaching of research and research literacy. In 2020, the website welcomed 12,864 new users and garnered 45,571 page views. In addition to the website, we maintain an active social media presence as well as a monthly email newsletter with more than 2,000 subscribers. Our Twitter account makes, on average, 3,797 impressions per month, with over 570 followers (@TransformChap1). These efforts help ensure that Transforming Chaplaincy reaches people at all points in their chaplaincy career, transforming how the profession communicates its role, and energizing those exploring their entry into the field.

Ensuring a stable foundation for professional spiritual care also requires financial support that can initiate long-term viability and fund vital research. Building on the initial project activities, we secured $1.07M in support for additional initiatives, including a grant from the Luce Foundation to study the academic and clinical components of chaplaincy education (see Cadge et

al., 2019, 2020; Clevenger et al., 2020). In addition we completed a project supported by the Carpenter Foundation and others to study healthcare executives' understanding and evaluation of their spiritual care programs. Reports from this project are currently under review. The need for research within chaplaincy goes beyond understanding the individual implications of spiritual care and requires that researchers engage in dialogue with healthcare administrators to ensure system-wide inclusion.

Transforming Chaplaincy Research Fellows – Results

By the end of the initial phase in 2019 the Transforming Chaplaincy project had supported 17 Chaplain Research Fellows who completed a Master of Public Health or related degrees (see photo). These degrees were earned at a number of different schools including University of Michigan, University of Minnesota, University of Illinois, Emory University, University of South Carolina, Virginia Commonwealth University, and University of Louisville. As of the end of the fellowship program (June 2019), the Fellows were authors or co-authors of nearly 30 articles or book chapters (see below). Petra Wahnefreid Sprik, one of the Fellows, received 3rd prize in the 2018 Spirituality & Public Health Student Essay Contest (Oman & Long, 2019). The Fellows also made over 100 presentations, including three at international meetings.

As of Fall 2020, four of the Fellows are in PhD programs, and of these, two are PhD Candidates. These Fellows, with their schools/departments and areas of research, are as follows:

> *Kristin Godlin* is in the Community Health program at University of Illinois. The focus of Kristin's research is on religious coping with Intimate Partner Violence (IPV). She has examined faith-related variables as predictors of posttraumatic growth in female survivors of IPV. Her dissertation will explore women's conceptualizations of forgiveness and their relationship to three health outcomes: decisions to stay in abusive relationships, resilience, and well-being.
>
> *Geila Rajaee* is a PhD Candidate in the Department of Health Behavior and Health Education, University of Michigan, School of Public Health. Her research interests include spirituality/religion, chaplaincy, management of chronic disease, and behavioral interventions to improve health outcomes. Geila is particularly interested in preventable chronic diseases (e.g., diabetes) and the role of chaplains in mitigating and managing adverse health outcomes.
>
> *Timothy J. Usset* is in the Health Services Research, Policy & Administration program in the Health Policy & Management Division, University of Minnesota, School of Public Health. Tim has worked extensively with moral injury, spiritual distress, and posttraumatic stress disorder on numerous research projects and clinical areas within the Veterans Health Administration. In his PhD, Tim plans to expand his focus to examine the impact of moral distress, moral injury, and burnout on healthcare worker well-being and patient health outcomes.
>
> *Kelsey White* is a PhD Candidate in the Department of Health Management and System Sciences, School of Public Health and Information Sciences, at the University of Louisville. Her studies focus on health services research and organizational theory. Specifically, she is exploring how healthcare delivery systems provide access to professional spiritual care and utilize chaplains.

The other 13 Fellows are working as chaplains or chaplain researchers in major medical centers across the country. Together the Fellows have substantially expanded the number of healthcare chaplains who can advance spiritual care through

research – operating as bridge builders between disciplinary fields. They are also active in teaching research literacy to their chaplaincy colleagues and chaplains in training.

Continuing to Transform Chaplaincy

Transforming Chaplaincy has built on its initial four-year phase and is becoming an on-going center for spiritual care related research and research literacy education for chaplains. Through Rush University Medical Center, we currently offer two on-line research literacy courses for chaplains covering topics of evidence-based spiritual care and research literacy. Recently 50 staff chaplains from a large healthcare system in Texas all completed the first of these courses, and the other course has engaged an international audience with chaplains from Europe and Australia. We plan for the in-person Chaplain Summer Research Institute to resume in the summer of 2022.

The second ongoing focus for Transforming Chaplaincy is supporting chaplains to directly apply their newly enhanced research skills in interdisciplinary and spiritual care research efforts. To accomplish this we developed eight research networks that bring together chaplains, chaplain researchers, and non-chaplain researchers who share an interest in a common area. Among the areas addressed by the networks are spiritual care in hospice and palliative care, spiritual care in cancer care, including out-patient care, and spiritual care for people who have experienced trauma.. We are also building new initiatives around spiritual care in the Covid-19 pandemic and examination of racial differences in spiritual care. We are eager to have non-chaplain clinical and research colleagues participate in the networks. More information about the networks and how to join them is available at the Transforming Chaplaincy website.

Seeking Partners

Finding funding for research about spiritual care is at least as challenging as finding funding for research about religion, spirituality and health. For Transforming Chaplaincy, a key strategy for advancing this research is to develop partnerships with interested research colleagues and organizations. We have begun to build partnerships with clinicians and researchers in some areas such as palliative care. We are eager to expand these partnerships and networks and would welcome hearing from readers of the *Bulletin* who would like to know more about our work or to explore potential collaborations. To stay informed about our work we invite you view our website where you may also sign up for our monthly Transforming Chaplaincy newsletter (www.transformchaplaincy.org/).

Chaplaincy Research in the 21st Century

Enhanced research on chaplaincy holds promise for fostering improved integration of chaplaincy with other professions and activities within healthcare systems, and enhancing systemic functioning and patient outcomes in ways that have long been recognized as vital by public health. The utilization of research within healthcare chaplaincy will continue to evolve as chaplains, at all stages of their careers, expand their research literacy and integrate in research communities. We hope that these efforts not only provide a strong evidence-base for spiritual care, but that we also begin to see chaplains assume a more prominent role within public health education and community public health efforts. Future research must expand beyond examining the importance of religion and spirituality for health, and examine chaplaincy care within public health services, such as preventative screening, and chaplaincy care at the organizational level. For example, such research may explore how chaplaincy care influences utilization of preventive health services, adherence to medical treatments, or advance into health economic evaluation to document the cost-benefit or cost-effectiveness of chaplaincy interventions (Oman & Brown, 2018). As chaplaincy research grows so does chaplains' integration and collaboration with public health professionals and with professionals across the spectrum of healthcare delivery.

Transforming Chaplaincy is one example of work that attempts to link a variety of interlocking fields: spiritual care, clinical care, public health, and research. We hope that our efforts embolden others towards initiatives that build cross-disciplinary skill sets that can expand and deepen our shared capacity to care for all aspects of human health and wellbeing, particularly in times of struggle.

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Resources & Updates: Fall 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

- In this issue: Doug Oman, Covid-19 and Religion/Spirituality: A Global Review from a Public Health Perspective (please see bibliography for an expanded list of resources)
- PHRS Board Member, Susan Holman, Disease, Community, and Grief in a COVID-19 World
- International Dialogue Centre (KAICIID), Interfaith Dialogue in Action on COVID-19
- Essay by Mark Faries, Texas A&M Professor of Behavioral and Lifestyle Medicine: Voices: COVID-19 and the concern of chronic disease in the church
- Essays reflecting on tensions between COVID-19 restrictions, illness prevention, and Eucharist in Orthodox Christian communities: Public Orthodoxy and Eucharist and Do the Sacraments Prevent Illness?
- November 2020: Spirituality, religiosity and the mental health consequences of social isolation during Covid-19 pandemic (Lucchetti et al.), *International Journal of Social Psychiatry*
- October 2020: National Well-Being Measures Before and During the COVID-19 Pandemic in Online Samples (VanderWeele et al.), *Journal of General Internal Medicine*
- October 2020: Coping with Racism: a Perspective of COVID-19 Church Closures on the Mental Health of African Americans (DeSouza et al.), *Journal of Racial and Ethnic Health Disparities*
- October 2020: Relationships between religion/spirituality and mental health in youth during COVID-19 (Kang et al.), *Journal of the American Academy of Child and Adolescent Psychiatry*
- September 2020: Emergency department approach to spirituality care in the era of COVID-19 (Pierce et al.), *The American Journal of Emergency Medicine*
- July 2020: The role of spirituality in the COVID-19 pandemic: a spiritual hotline project (Ribeiro et al.), *Journal of Public Health*
- July 2020: A look at the first quarantined community in the United States: Response of religious communal organizations and implications for public health during the COVID-19 pandemic (Weinberger-Litman et al.), *Journal of Religion and Health*
- June 2020: Religion as a Health Promoter During the 2019/2020 COVID Outbreak: View from Detroit (Modell & Kardia), *Journal of Religion and Health*
- May 2020: COVID-19 Epidemic and Spirituality: A Review of the Benefits of Religion in Times of Crisis (Fardin), *Jundishapur Journal of Chronic Disease*
- For more COVID-19/PHRS resources, please see the PHRS resource page: http://www.publichealthrs.org/resources/

New Research & Materials

- November 2020: Mantram Repetition as a Portable Mindfulness Practice: Applications During the COVID-19 Pandemic (Oman et al.), *Mindfulness*
- November 2020: Integrating spirituality and mental health: Perspectives of adults receiving public mental health services in California (Yamada et al.), *Psychology of Religion and Spirituality*
- October 2020: Forgiveness of others and subsequent health and well-being in mid-life:

a longitudinal study on female nurses (Long et al.), *BMC Psychology*
- October 2020: Policy Brief: Religious Networks, Their Impact on SDGS (SDG17), and the Challenges for the International Legal Order (Petkoff et al.), *Think20 Saudi Arabia*
- October 2020: USAID Evidence Summit on Strategic Religious Engagement Research Papers
- October 2020: Second Victims: Aftermath of Gun Violence and Faith-Based Responses (Galiatsatos et al.), *Journal of Religion and Health*
- September 2020: Exploring the Impact of Religion and Spirituality on Mental Health and Coping in a Group of Canadian Psychiatric Outpatients (Adams et al.), *The Journal of Nervous and Mental Disease*
- August 2020: Religious-service attendance and subsequent health and well-being throughout adulthood: evidence from three prospective cohorts (Chen et al.), *International Journal of Epidemiology*
- August 2020: The International NERSH Data Pool of Health Professionals' Attitudes Toward Religiosity and Spirituality in 12 Countries (Kørup et al.), *Journal of Religion and Health*
- July 2020: Spiritually Motivated Self-Forgiveness and Divine Forgiveness, and Subsequent Health and Well-Being Among Middle-Aged Female Nurses: An Outcome-Wide Longitudinal Approach (Long et al.), *Frontiers in Psychology*
- 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 & Balboni), *BMC Public Health*
- April 2020: Effects of Religious Service Attendance and Religious Importance on Depression: Examining the Meta-analytic Evidence (VanderWeele), *The International Journal for the Psychology of Religion*
- March 2020: Antecedents of purpose in life: Evidence from a lagged exposure-wide analysis (Chen et al.), *Cogent Psychology*
- January/February 2020: A Pilot Study on Sleep Quality, Forgiveness, Religion, Spirituality, and General Health of Women Living in a Homeless Mission (Brewer-Smyth et al.), *Holistic Nursing Practice*

Articles, Commentaries, Interviews, Webinars

- WHO Special Bulletin Call for Papers on Behavioural and Social Sciences For Better Health. **Manuscript submission open until December 31, 2020.**
- Podcast, "Religion as a Social Determinant of Health" with Ellen Idler, Recorded Talk from October 23, 2020
- Conversations in Religion and the Healing Arts, Recorded event from Valparaiso University, Oct 14, 2020
- Lecture by Prof. David Nirenberg, Dean of the University of Chicago Divinity School: What Pandemics Mean for Religion, Recorded Talk from July 2, 2020

Upcoming Conferences & Conference Minutes

- UPCOMING: Virtual Conference on Religion and Medicine, March 22-24, 2021: **Abstracts open until Dec 1:** http://www.medicineandreligion.com/
- UPCOMING: International, interfaith, interdisciplinary "virtual" symposium: "Fostering Faith, Forgiveness and Flourishing for Victims of Childhood Sexual Abuse" April 8–10, 2021. Keynote address by Rev. Dr. Denis Mukwege, 2018 Nobel Peace Prize Laureate. This event aims to provide a diverse range of topics and research from a variety of faiths, disciplines, and perspectives. For presenting a case study or research paper please see further details and upcoming submission deadlines at: https://hfh.fas.harvard.edu/Symposium-On-Child-Abuse
- PAST: American Public Health Association Annual Meeting, October 24, 2020: Business Meeting of the Caucus on Public Health and the Faith Community