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Editors' Introduction: Fall 2021 Issue #5

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

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

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

Warmly,

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NIH and NIMH Research and Strategic Planning Must Address Religion and Spirituality

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

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

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 Such outdated underfunding arguably contributes to many unfavorable outcomes, ranging from poorer clinical care to poorer governmental and health-system responses to the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

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

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

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

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

Appendix A: Submitted Comments

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

David Rosmarin submitted a brief comment:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

References

Balboni, M. J., & Peteet, J. R. (Eds.). (2017). *Spirituality and religion within the culture of medicine: From evidence to practice*. New York, NY: Oxford University Press.

Idler, E., Levin, J., VanderWeele, T. J., & Khan, A. (2019). Partnerships between public health agencies and faith communities [introduction to special section on pp. 361–386)]. *American Journal of Public Health, 109*(3), 346-347. https://doi.org/10.2105/ajph.2018.304941

Newport, F. (2012, December 4). Seven in 10 Americans are very or moderately religious. http://www.gallup.com/poll/159050/seven-americans-moderately-religious.aspx Accessed 7 Oct 2021.

Newport, F. (2016, December 23). Five key findings on religion in the US. http://www.gallup.com/poll/200186/five-key-findings-religion.aspx Accessed 7 Oct 2021.

Oman, D. (Ed.). (2018). *Why religion and spirituality matter for public health: Evidence, implications, and resources*. Cham, Switzerland: Springer International. https://doi.org/10.1007/978-3-319-73966-3

Oman, D., & Syme, S. L. (2018). Weighing the evidence: What is revealed by 100+ meta-analyses and systematic reviews of religion/spirituality and health? In D. Oman (Ed.), *Why religion and spirituality matter for public health: Evidence, implications, and resources* (pp. 261-281). Cham, Switzerland: Springer International. https://doi.org/10.1007/978-3-319-73966-3_15

RSHSIG (2021). "Religion, Spirituality, and Health Scientific Interest Group." National Institutes of Health, Office of Intramural Research. https://oir.nih.gov/sigs/religion-spirituality-health-scientific-interest-group (accessed 6 Oct. 2021).

Vieten, C., & Lukoff, D. (2021). Spiritual and religious competencies in psychology. *American Psychologist*. (online publication before print). https://doi.org/10.1037/amp0000821

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

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Interview with Rabbi Professor Nancy E. Epstein

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

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

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

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

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

Rabbi Prof. Nancy Epstein

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ashley Meehan[1]

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

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

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

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

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

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

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

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

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

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

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Resources & Updates: Fall 2021

PHRS Staff

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

New Research

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

NIH Spirituality Listserv

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

Upcoming Conferences & Webinars

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

Recent Conferences & Webinars

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