Elephant in the Room: Why Spirituality and Religion Matter for Public Health

Doug Oman

Abstract This chapter introduces the book *Why Religion and Spirituality Matter for Public Health: Evidence, Implications, and Resources*. More than 3000 empirical studies 100 systematic reviews have been published on relations of religion and/or spirituality (R/S) with health, but R/S factors remain neglected in public health teaching and research. R.S reflects ultimate concern that taps deep motivations, and R/S typically encourages stewardship of health, so its health-relevance is unsurprising from a behavioral motivation perspective. R/S engagement also commonly fosters social support and access to distinctive methods of coping with stress, elements of a "generic model" of how R/S influences health. Predominantly favorable relations suggest that R/S might be a fundamental cause of health, but R/S factors also sometimes correlate unfavorably with risk factors or poorer health. Part I of this volume contains 14 chapters that review evidence on R/S-health relations from the perspectives of major subfields of public health that include social factors, nutrition, infectious diseases, environmental health, maternal/child health, health policy and management, public health education and promotion, mental health, and clinical practice. Part II contains two chapters that address implications for public health practice, emphasizing community-based health promotion, health policy advocacy, and healthcare systems and management. The eight chapters in Part III offer resources for public health educators, including narratives of how R/S-health relations have been taught in schools of public health at universities that include Emory, Harvard, University of California at Berkeley, Boston University, University of Michigan, Drexel University, and University of Illinois at Chicago. A concluding chapter offers international perspectives.

Keywords Religion · Spirituality · Public health · Health behavior · Social support · Religious coping · Ultimate concern · Systematic review · Fundamental cause · Education

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To its own detriment, the field of public health has ignored a proverbial elephant in the room: An enormous body of empirical evidence that now links religious and spiritual (R/S) factors to health – and very commonly to *better health*. As documented in this book, in the past 20 years, refereed journals have published more than 100 systematic reviews on relations between religion, spirituality and health, revealing potentially causal relationships. Despite this explosion of interest, however, R/S factors remain neglected in curricula and research in public health, when compared with the attention they receive from many other health-related fields such as medicine, psychology, and nursing. This book aims to provide a way out of the intellectual blindness into which the public health field has unintentionally wandered: This book aims to empower public health professionals by offering key resources for acknowledging the elephant in the room and harnessing its power for good, without permitting it to stray beyond appropriate channels. More specifically, this volume is intended as a handbook to orient public health educators, students, researchers, and practitioners to the theoretical and empirical research base on religion/spirituality and health, its implications for practice, and how it can be communicated to future generations of public health professionals.

The tremendous health-relevance of religion and spirituality documented here may be viewed as both surprising and unsurprising. It may be surprising from the point of view of the "secularization theory" that was popular in the 1960s and 1970s (e.g., Berger 1967; Swatos and Christiano 1999). In vogue when many current public health leaders received their academic training, secularization theory predicted that the advance of science would soon render religious worldviews irrelevant and outmoded, causing them to fade from public life. Yet the resurgence of religious movements in the US and worldwide since the late 1970s rendered such secularization theory *itself* obsolete, even in the perceptions of many of its influential original proponents (e.g., Berger 1999). Unfortunately, *practical* resources for going beyond secularization theory have been slow to emerge in the field of public health.

Yet the health-relevance of religion/spirituality is arguably *not* surprising when viewed from the science of behavioral motivation (Ford 1992; Emmons 1999). The motivation of communities and individuals to adopt improved health behaviors is central to much public health practice. Spirituality and religion are profoundly relevant to motivation because they commonly reflect our *ultimate concerns*, our deepest motives, in the memorable phrasing of theologian Paul Tillich (1951). Potential actions for health that people clearly recognize as *aligned* with their ultimate concerns will be experienced as more powerfully motivating. Happily, stewardship of one's health is recognized in many religions as in part a sacred responsibility. We should therefore not be surprised that measures of religion and spirituality show overwhelmingly favorable patterns of associations with most types of individual health behaviors (see chapter "Model of Individual Health Effects from Religion/Spirituality: Supporting Evidence," this volume). Religious communities, too, are commonly committed to stewardship of the health of their members and often also of the wider society, undertaking intentional health promotion activities ranging from provision of parish nurses to campaigns for environmental justice (see, for example, chapter "Environmental Health Sciences, Religion, and Spirituality," this

volume; Brudenell 2003). Importantly, on both the individual and community levels, engagement in spirituality and/or religion commonly gives access to social support and a wide range of other coping resources, some of them distinctive to religion/spirituality (Pargament 1997; Pargament et al. 2000). Such coping resources can mitigate distress, reduce "allostatic load" (Seeman et al. 2001), and prevent or reduce physiological damage from excessive stress.

Yet religion as it exists in the real world is not uniformly associated with favorable health factors and outcomes. For example, despite generally favorable relations, several chapters in this volume describe evidence that some dimensions of religion, such as fundamentalism, have frequently been found to correlate with less concern for the environment, more discriminatory attitudes against ethnic, religious, or sexual minorities, and sometimes poorer health behaviors and outcomes (see chapters in this volume on social factors, discrimination, and environmental health). It is very important, therefore, not to oversimplify the relation between R/S factors and health. The question, "Are religion and spirituality related to better health?" is thus too simple. We agree with Pargament's (2002) recommendation to instead ask the richer question, "How helpful or harmful are particular forms of religious expression for particular people dealing with particular situations in particular social contexts according to particular criteria of helpfulness or harmfulness?" (p. 168). This does not mean that the generally favorable R/S-health associations are a mere coincidence that holds no significance. Several mediating pathways were noted earlier, and some investigators have gone further, speculating that religion/spirituality might be a "fundamental cause" of health in the sense that they tend to "maintain an association with disease even when intervening mechanisms change" (Link and Phelan 1995, p. 80) (see Hummer et al. 1999, chapters "Social and Community-Level Factors in Health Effects from Religion/Spirituality," and "Weighing the Evidence: What is Revealed by 100+ Meta-Analyses and Systematic Reviews of Religion/Spirituality and Health?" this volume). Several chapters sketch a "dynamic and evolving" understanding of religion/spirituality that may help reconcile the observation of some negative relations with the notion of R/S as a fundamental cause (e.g., see chapter "Social and Community-Level Factors in Health Effects from Religion/Spirituality," and Q6 in chapter "Questions on Assessing the Evidence Linking Religion/Spirituality to Health," this volume). Viewing religion/spirituality as a fundamental cause of health may therefore be plausible and worth considering, but such a view must also contend with the mixed empirical patterns as reported in this volume.

Readers who explore the rich set of reviews and practical and educational resources contained in this volume should be aware of several other important characteristics of the growing body of scientific research on R/S and health. First, few if any empirical researchers on R/S-health relations regard their findings as implying any conclusions about the truth claims of specific religious traditions, or of religion in general. Such questions are generally regarded as untestable through empirical data, an agnostic stand that has also been emphasized by major R/S-health researchers in fields such as medicine and psychology (e.g., Koenig et al. 2012; Miller and Thoresen 2003).

1 Spirituality and Religion: What Are They?

But the inability to draw metaphysical conclusions does not mean that people's religious and spiritual engagement cannot be measured. As noted by numerous scholars across the humanities as well as social and biomedical sciences, religion and spirituality are increasingly viewed as distinct from each other. However, neither term possesses a consensus definition (Oman 2013). Different empirical studies have used a wide range of empirical measures of religion and spirituality, a fact that must be kept in mind when interpreting or reviewing the literature. Despite this complexity, several recurring themes can greatly assist in navigating this literature.

First, in contemporary English, "spirituality" has come to connote something more individual and experiential, perhaps involving experiences of transcendence or of the sacred. The term "spirituality" is also often perceived as a more universal and inclusive term, even by many people who do not hesitate to self-identify as religious. In contrast, "religion" has come to connote something more organized or institutional, such as the established religion observable in churches. Consistent with this modern usage, a substantial fraction of US adults now describe themselves as "spiritual but not religious,"[1] reflecting spiritual concerns or experiences ostensibly pursued in ways independent of organized religion (Hastings 2016). Yet only a century ago, spirituality was widely viewed as something inseparable from religion, perhaps as something expected especially of a person who was deeply religious. Responding in part to this change in usage, a growing research literature now explores the meanings that these terms hold for ordinary US adults as well as the ways that they might be usefully defined as technical terms (Ammerman 2013; Hastings 2016; Oman 2013; Wuthnow 1998; Zinnbauer et al. 1997).

Evidence from national surveys as well as personal observation suggest to the present author that "spiritual but not religious" identities may be even more common among public health faculty and students than among the general US population (see chapter "Introduction: What Should Public Health Students Be Taught About Religion and Spirituality?," this volume). Among University of California at Berkeley students, one can find large numbers who identify as "spiritual but not religious" as well as large numbers self-identifying as religious. The present author has structured his teaching to present the R/S-public health topic in ways engaging to both audiences (see chapter "An Evidence-Based Course at U.C. Berkeley on Religious and Spiritual Factors in Public Health," this volume).

[1] Estimates of the fraction of US adults who view themselves as spiritual but not religious have varied, perhaps in part due to different ways of asking the question. Up to 33% of respondents in national surveys have reported they were "spiritual but not religious," when given the alternatives of "religious" (50%) and "neither" (11%) (Gallup Poll 2002, with 4% volunteering that they were both spiritual and religious). However, Hastings (2016) reports that in the US General Social Survey, percentages increased from 1.9% in 1998 to a maximum of 6.7% in 2014, when measured as respondents who rarely or never attended religious services and who considered themselves "very or moderately spiritual" (p. 68).

Rather than impose a single definition of the terms "spirituality" and "religion," most chapters in this volume reflect how these terms have been used in the professional literatures under consideration in each chapter. Importantly, however, certain simplifying perspectives can support successful navigation of most uses of these terms in this volume. First, spirituality and religion are widely viewed as closely related: A number of surveys suggest or indicate that most US adults identify themselves as *both* "religious" *and* "spiritual" (Ellison et al. 2012; Marler and Hadaway 2002). In addition, many people hold that the primary or core *purpose* of religious traditions is to foster spirituality. "Viewed in this way," Miller and Thoresen (2003, p. 28) point out, "the field of religion is to spirituality as the field of medicine is to health." That is, even as a person may pursue health outside of organized medicine – seeking to be healthy without recourse to a physician – it is also quite possible to pursue spirituality outside of religion – seeking to be spiritual without recourse to organized religion.[2] Consistent with such approaches, religion and spirituality are commonly said to be *partly overlapping* constructs (Miller and Thoresen 2003; Zinnbauer et al. 1997).

Second, spirituality and religion are each widely understood as multidimensional. They are multidimensional because a person may be high in one dimension – such as frequency of attendance at worship services – while being low in another dimension, such as the frequency of private prayer. Such an approach is foundational to most of the recent quantitative study of religion/spirituality. Commonly studied dimensions have included people's preferred denomination, frequency of attendance at worship services, frequency of prayer, and other aspects such as a person's subjective sense of commitment to religion or spirituality.

Third, a simultaneous blessing and challenge for research on R/S and health is the existence of literally hundreds of published R/S measures that were generated for diverse purposes over many decades (e.g., Hill and Hood 1999). Most R/S--health studies have employed a comparatively small number of measures. To simplify the choice process, especially for new researchers, the National Institute on Aging helped produce an influential collection of short questionnaire measures for easy inclusion in health surveys (Fetzer 1999; see also Table 1 in chapter "Questions on Assessing the Evidence Linking Religion/Spirituality to Health," this volume). Certain dimensions of religion, such as denominational affiliation and frequency of attendance at religious services, are easy to measure through single-item self-reports, and have been included in large community-based surveys for more than half a century. Spirituality measures tend to be lengthier. A substantial body of

[2] Some readers may also find useful an influential set of definitions that have been offered by psychologist Kenneth Pargament (1997). He suggests defining spirituality as a "search for the sacred," and defining religion (or religiousness) as a "search for significance in ways related to the sacred" (p. 32). More recently, he offered an alternative definition of religion as "the search for significance that occurs within the context of established institutions that are designed to facilitate spirituality" (Pargament et al. 2013, p. 15). According to this later definition, religion is broader than spirituality in its function, but narrower than spirituality in its institutional base. Pargament's framework has been found relevant to both Western (Abrahamic) and Indian (Dharmic) traditions (Oman and Paranjpe 2017).

validated spirituality scales has only recently become available (e.g., de Jager Meezenbroek et al. 2012; Kapuscinski and Masters 2010; Selman et al. 2011). Studies of the health effects of spirituality, especially non-religious forms of spirituality, are therefore scarce and represent an important and greatly needed emerging subfield. Finally, a small body of empirical research has studied the health effects of community-level religion/spirituality by employing counts of congregations or other neighborhood-level or community-level measures (Bartkowski et al. 2011; Jaffe et al. 2005, p. 807) (see chapter "Social and Community-Level Factors in Health Effects from Religion/Spirituality," this volume). Additional information about available R/S measures and the commonly studied R/S dimensions is provided in chapter "Questions on Assessing the Evidence Linking Religion/Spirituality to Health" (this volume).

2 Keeping Pace with an Enormous Research Base

What, then, are the health consequences and implications of religious and spiritual engagement? Many newly-alerted health professionals are astonished to learn that the aforementioned multidimensional approach to spirituality and religion has now generated a research base of more than 3000 empirical studies and more than 100 systematic reviews and meta-analyses. Studies have been published in major refereed journals in disciplines that include not only public health, but also medicine, psychiatry, psychology, nursing, social work, gerontology, geriatrics, and demography. Among the most dramatic findings has been numerous studies and meta-analytic evidence linking religious involvement, most commonly measured as frequency of attendance at religious services, with an approximately 20% reduced hazard of mortality (Chida et al. 2009, Hazard Ratio = 0.82, $p < 0.001$, based on $k = 59$ studies) (see also chapter "Religious/Spiritual Effects on Physical Morbidity and Mortality," this volume). One nationally representative study of more than 20,000 US adults reported that R/S measures were associated with a longevity gap of more than 7 years in the general population, and nearly 14 years among African Americans, and in multivariate models was associated with hazard reductions comparable to benefits from avoiding heavy smoking (Hummer et al. 1999, Odds Ratio = 1.63 for current heavy smoking, Odds Ratio = 1.50 for never attending worship services).

Not surprisingly, navigating an interdisciplinary literature of more than 3000 studies can be challenging. Orientation is aided by knowing a few of the field's key events and reference points. One major resource that has helped shape the R/S--health field is two handbooks assembled by Harold Koenig, a physician at Duke University (Koenig et al. 2001; Koenig et al. 2012). Koenig and his colleagues have exhaustively catalogued, quality-rated, and summarized findings from more than 1200 empirical studies published in the twentieth century, and more than 2100

additional studies published in the first decade of the twenty-first century.[3] While Koenig's handbooks emphasize medical perspectives and effects on individuals rather than communities, these handbooks were invaluable aids in preparing the present volume's reviews oriented toward public health.

The first comprehensive literature reviews of the R/S-health field were published in the late 1980s, and soon thereafter, in the late 1990s, the number of empirical R/S-health studies published per year began to accelerate considerably. As the volume expanded dramatically, several prominent and highly cited longevity studies were published in the *American Journal of Public Health*. They offered some of the most compelling evidence to date of health effects, and appear to have helped consolidate the emerging field's increasingly mainstream status (Kark et al. 1996; Oman and Reed 1998; Strawbridge et al. 1997). Soon thereafter, the field was further boosted and consolidated by the publication of the National Institute on Aging's sponsored book of measures and Koenig's first *Handbook*, noted earlier, as well as an overview of the emerging field in the *Annual Review of Public Health* (Chatters 2000).

But ironically, after these early contributions nearly two decades ago, public health has largely failed to follow through in a coherent, coordinated, or integrative manner. This stands in contrast to several other health-related fields. In medicine, more than three quarters of US medical schools now address R/S-health issues in their curricula, and important sourcebooks are supporting the topic's integration into global medical practice and teaching (Cobb et al. 2012; Lucchetti et al. 2012). Modeled on the Accreditation Council for Graduate Medical Education competencies, a consensus meeting of physicians has proposed the National Competencies in Spirituality and Health, along with measurable behavioral objectives (Puchalski et al. 2014). In psychology, the American Psychological Association (APA) has published nearly 20 books on spirituality and health since the late 1990s, including a nearly 2000-page *Handbook*, containing volumes on basic science as well on application (Pargament 2013). Meta-analyses of randomized trials of spiritually-infused psychotherapies have been published (Worthington et al. 2011), along with proposed sets of religious/spiritual competencies for professional psychologists (Vieten et al. 2013, 2016). Parallel efforts to address spirituality/religion have been common in nursing for decades, and are now emerging in social work (Hodge 2007; Ross 2006; Van Leeuwen et al. 2009).

In contrast, public health has been largely "missing in action." The American Public Health Association has to our knowledge published only a single book about the health relevance of spirituality or religion. This well-done volume, unfortunately now out of print, focused entirely on skills for collaboration with churches, and did not attend to the emerging R/S-health evidence (Tuggle 2000). The only *Annual*

[3] "The first edition contained information on "over twelve hundred research studies conducted from the 1800s up to the year 2000," and the second edition included "over twenty-one hundred *quantitative* studies exami9ning the religion-health relationship during the ten years between 2000 and 2010…. We estimate that this review covers about 75 percent of the existing research" (Koenig et al. 2012, pp. 5, 9, emphasis in original).

Review of Public Health article since 2000 that focused on religious/spiritual factors was similarly well-done and valuable, but was also dedicated to collaboration rather than offering a broader consideration (Campbell et al. 2007). We need not be surprised, therefore, that most contemporary American students who graduate with a Master of Public Health or a Doctorate of Public Health degree appear to learn little or nothing about R/S-health relations in the course of their training, and some may even develop misunderstandings, such as the belief that religious or spiritual engagement has seldom been subjected to scientific study.

But potential for change also exists. Public health leaders and students demonstrate much interest in learning about religion and public health. When we conducted a national survey of public health graduate students in 2013, we found that a majority (53%) of respondents thought that too little attention in the public health curriculum had been devoted to consideration of theory and evidence about spiritual and religious factors. Almost none (about 1%) thought that too much attention had been devoted to R/S factors. More than one-third (34%) reported that no attention whatsoever had been given to R/S factors as potential causal influences on health (see chapter "Introduction: What Should Public Health Students Be Taught About Religion and Spirituality?," this volume).

Why, then, is public health "missing in action" in educating its students on the massive emerging R/S-health literature? Multiple explanations likely apply. Senior academics who long ago imbibed secularization theories may find it difficult to maintain the open mind needed to assimilate the evidence, even when they are exposed to it. Others who lack personal experience or training on the nature of religion/spirituality may be reluctant to open discussion of a topic they view as beyond their expertise. Others may have an erroneous impression that the US constitutional separation of church and state renders spiritual and religious factors irrelevant to practical and effective public health practice (see chapter "Health Policy and Management, Religion, and Spirituality," this volume). Still other professionals may never have encountered R/S-health issues, or may have the erroneous impression that religious/spiritual effects are reducible to the effects of other factors such as social support, are too small to be relevant to interventions, or are not predominantly favorable.

All of these explanations may apply, and more. But a more important question is understanding how public health might take steps to improve the situation. To gain insight on this question, my colleagues and I in 2013 also conducted a national survey of deans of schools of public health (see chapter "Introduction: What Should Public Health Students Be Taught About Religion and Spirituality?," this volume). One question asked "what resources [would you] consider most helpful or needed for properly addressing religious and spiritual factors in teaching." The answers were quite helpful, and also quite varied. Several of the leaders expressed a need for rigorous reviews (e.g., requests for "logic model or summary of the evidence," "data and rigorous analysis," "evidence based resources on how to effectively address religious and spiritual factors in educational activities," "published research and practice examples of successful interventions"). In important ways, this book represents an attempt to respond to these requests for resources. In an equally fundamental

sense, this book represents our attempt to empower our public health colleagues by supplying tools for offering the improved education desired by our graduate student survey respondents.

3 Using This Book

The present volume aims, as much as possible, to be a "one stop shopping" resource for public health students and professionals who want to improve how they address religious and spiritual factors in public health. It is directed at public health practitioners as well as academic public health educators and students. Consistent with the evidence-based nature of modern public health, it devotes a great deal of attention, in Part I, to the scientific theory and empirical evidence base for the public health relevance of R/S factors. Later sections are addressed to public health professionals in particular settings. Part II addresses implications for public health *practice*, addressing public health professionals working in health departments or a wide range of other community-based or governmental health-promotion settings. Part III addresses implications for educators training public health students. A concluding chapter addresses international implications. The following paragraphs offer additional orientation for each of these major sections.

Part I offers reviews of empirical evidence. Most of its 15 chapters cover the R/S--health evidence that is relevant to a particular subfield within public health, such as public health education, health policy and management, or environmental health sciences. The chapter "Reviewing Religion/Spirituality Evidence from a Public Health Perspective: Introduction" introduces the other chapters, describing common structure, and contextualizing by national enrollment statistics in different public health majors. This chapter also explains that the reviews give the bulk of their attention to understanding the health implications of peoples' degree of religiousness/spirituality, rather than attempting to track denominational differences in health status (e.g., Catholic versus Protestant), which may vary over time and are subject to many sources of confounding. The chapter "Questions on Assessing the Evidence Linking Religion/Spirituality to Health", the last chapter in Part I, describes common methods used in the reviews, as well as offering some basic information on the nature of spiritual and religious engagement and their US and worldwide prevalence.

The first substantive review is the chapter "Model of Individual Health Effects from Religion/Spirituality: Supporting Evidence" (this volume). This chapter presents evidence bearing on (and generally supporting) what is sometimes called the "generic model," a framework widely used to conceptualize how religious/spiritual engagement influences individual health through pathways such as improved health behaviors, social support, and the availability of religious/spiritual methods of coping. We also explain how the model relates to what we call "borderline spiritual constructs," factors such as mindfulness and yoga that are often viewed as somehow related to spirituality, and can be pursued in either sacred or secular contexts. It

contains a condensed overview of empirical links between religion/spirituality and morbidity and mortality (Box 1), as well as ideas for application to public health practice (Box 2) that may make this chapter, "Model of Individual Health Effects from Religion/Spirituality: Supporting Evidence," especially useful for course instructors who wish to assign a single general introductory reading that cuts across public health subfields. Readers needing or seeking a more in-depth review of empirical findings on how R/S affects individual morbidity and mortality will find it in the next chapter, chapter "Religious/Spiritual Effects on Physical Morbidity and Mortality".

The fourth chapter in Part I, "Social and Community-Level Factors in Health Effects from Religion/Spirituality" (this volume), strikes out in a new direction that reflects approaches especially distinctive to public health as a community-oriented field. This chapter offers an explicit model of how religion/spirituality as well as other health-protective and health-risk factors may exist at both the level of the community and the level of the individual. Indeed, community-level factors have been a major emphasis of the comparatively new field of social epidemiology (Berkman et al. 2014). This chapter reviews evidence linking community-level measures of religion/spirituality with health outcomes, as well as empirical evidence concerning the somewhat complex relations of religious/spiritual factors with factors of major social epidemiologic interest, including social capital, socio-economic status, income inequality, and social support, as well as crime and violence, and the prospects for multi-level interventions involving R/S factors. The focus on factors of major interest to social epidemiology is continued in the next chapter, "Social Identity and Discrimination in Religious/Spiritual Influences on Health" (this volume).

Most of the remaining chapters in Part I also review R/S-health evidence from the perspective of specific public health subfields. Each chapter's lead author is this volume's editor (Doug Oman), whose major research interest for the past two decades has been R/S-health relations. However, many chapters were coauthored by an expert in the specific subfield, ensuring that the chapter was well-grounded in the subfield's relevant theoretical frameworks and literature. When we first began assembling these review chapters in 2013, we were uncertain about whether our efforts would yield something clearly distinct from other recent reviews, such as the *Handbook* by Koenig et al. (2012). What emerged from our writing surpassed all our expectations. Repeatedly, we found that something important and new emerged when we rose to the challenge of directing our review to the community-oriented emphasis of a public health audience, with its distinctive needs, background, and theoretical orientation.

It is our hope that the various subfield-focused chapters in Part I can serve as important, path-breaking resources for our public health colleagues who, like the authors of these chapters, are scattered across many public health subfields. As discussed in Part III of this volume, we hope that each evidence-focused chapter can be a tool for educators in the corresponding subfield to teach about R/S factors in ways that are evidence-based, theoretically sophisticated, and respectful of diversity (see chapter "Introduction: What Should Public Health Students Be Taught About

Religion and Spirituality?," this volume). Besides social factors (chapters "Social and Community-Level Factors in Health Effects from Religion/Spirituality" and "Social Identity and Discrimination in Religious/Spiritual Influences on Health"), other subfield-oriented reviews focus on environmental health, infectious diseases, nutrition, maternal/child health, health policy and management, public health education, promotion, and intervention, mental health, and clinical practice.

The final review chapter steps back from public health and its subfields, offering instead an extremely broad overview based on a *review of reviews*. When we began preparing these various chapter reviews, we knew that we lacked the resources to independently re-review all of the more than 3000 empirical studies identified by Koenig's *Handbooks*. For feasibility, we realized that we needed to draw heavily on previous reviews conducted by others. To ensure high quality, we wanted to employ, whenever possible, refereed systematic reviews or meta-analyses. Our first step was therefore to prepare a catalogue of available systematic reviews concerning the relation of religion and/or spirituality to other variables of health interest.

What we found astonished us. We identified more than 30 meta-analyses and 100 relevant systematic reviews. Of these, a majority examined the relation of R/S factors to directly health-related variables such as longevity, health behaviors, coping styles, or mental health. We also identified several meta-analyses of randomized interventions (e.g., Worthington et al. 2011). A smaller number of systematic reviews examined relations with variables that we categorized as *indirectly* health-related, such as education (a primary and often highly health-predictive component of socioeconomic status – see, for example, Adler et al. 2013; Winkleby et al. 1992).

To our surprise, informal conversations with colleagues, including many seasoned researchers on spirituality/religion, revealed an almost uniform lack of awareness of the massive number of available systematic reviews. We believe the existence of these reviews is an important testament not only to how much is known about R/S factors, but also to the broad base of the R/S-health field, with the reviewing process itself having benefited from the efforts of hundreds of investigators and dozens of refereed journals, mostly not R/S-specialized, and many with high impact factors. As an aid to future research efforts, the identified reviews are catalogued in chapter ("Weighing the Evidence: What is Revealed by 100+ Meta-Analyses and Systematic Reviews of Religion/Spirituality and Health?," this volume). The chapter also elaborates upon some implications of these reviews, such as their contribution to evidence for a causal relation between religion/spirituality and health.

Part II offers a change of pace, shifting the focus from evidence to practice. It includes two chapters addressed to public health professionals working in health departments or other community-based or governmental health-promotion settings. Each includes an author or co-author with decades of experience in such applied public health work. Faith-health *partnerships* between health professionals and religious organizations are one important recurring theme. The chapter "Implications for Community Health Practitioners: Framing Religion and Spirituality Within a Social Ecological Framework", focused on community public health education, was written by Rabbi Nancy Epstein, MPH, a longtime leader of community-based health promotion efforts in Pennsylvania. Earlier in her career, Rabbi Epstein was a

legislative director of public health policy efforts in Texas, and the chapter also discusses policy advocacy. Similarly, the chapter "Implications for Public Health Systems and Clinical Practitioners: Strengths of Congregations, Religious Health Assets and Leading Causes of Life" was written by Teresa Cutts and Gary Gunderson, who have led efforts in Tennessee and North Carolina, as described in the chapter, to organize partnerships between religious communities and healthcare systems. Cutts and Gunderson have collaborated extensively with similar efforts in Africa.

Part III examines implications for public health *educators*. All chapters were written by public health faculty who have taught about religious/spiritual factors at schools of public health that are members of the Association of Schools and Programs of Public Health (ASPPH). The editor's introductory chapter, "Introduction: What Should Public Health Students Be Taught About Religion and Spirituality?," describes diverse styles, useful strategies, and needed and available resources for integrating R/S factors into academic public health education. The chapter also presents findings from the two recent national surveys, noted earlier, that document widespread perceptions of need for more teaching and improved teaching resources for R/S-health issues.

The remaining Part III chapters each focus on the experience of teaching about religious/spiritual factors in a particular school of public health. Authors were asked to briefly sketch the history of such efforts, as well as convey highlights of their own curricular approaches and achievements, in ways that might be helpful for others considering similar efforts. We hope that public health educators emboldened to undertake improved teaching about R/S factors will find sources of inspiration and guidance in the diverse narratives offered in this part. Like many other public health subfields, there is no standardized approach for teaching about religious/spiritual factors. Readers are free to emulate or adapt whichever approaches they find most engaging or resonant with their own teaching styles, and to reach out to available authors for more information.

Emory University's Rollins School of Public Health is the setting of the chapter entitled "Religion and Public Health at Emory University", by Ellen Idler and Mimi Kiser, perhaps this part's most impressive educational narrative. As they explain, teaching about R/S-health at Emory has benefited from funding through a university-wide strategic initiative, "Where Courageous Inquiry Leads," allowing an interdisciplinary team to establish a center that has taught at least nine different R/S-health courses, many offered through public health (see Table 1 of the chapter "Introduction: What Should Public Health Students Be Taught About Religion and Spirituality?"). Such efforts set a standard and show what is possible when R/S--health topics are prioritized in ways commensurate with their importance.

Other Part III chapters describe R/S-health teaching efforts at many major SPHs across the country, often culminating educationally in one or two courses, and not infrequently in opportunities for students to participate in mentored research or practice. Some chapters describe efforts that were launched recently, whereas others describe decades-old undertakings. These educational offerings reflect diverse pedagogical styles and content emphases that range from ethics to evidence to practice.

The contributions in this section include chapters from Harvard entitled "The Initiative on Health, Religion and Spirituality at Harvard: From Research to Education", from the University of California at Berkeley on "An Evidence-Based Course at U.C. Berkeley on Religious and Spiritual Factors in Public Health", from Boston University on "The Boston University Experience: Religion, Ethics, and Public Health", from the University of Michigan about "Faith Matters: "HBHE 710: Religion, Spirituality and Health" at the University of Michigan", from Drexel University on "Incorporating Religion and Spirituality into Teaching and Practice: the Drexel School of Public Health Experience", and from the University of Illinois at Chicago that describes "Online Teaching of Public Health and Spirituality at University of Illinois: Chaplains for the Twenty-First Century."

Finally, the volume's two concluding chapters attempt to put into perspective the rich material offered in the first three parts on evidence, practice, and education. The chapter on "International and Global Perspectives on Spirituality, Religion, and Public Health" (this volume), was lead-authored by Dr. Liz Grant, director of the Global Health Academy at the University of Edinburgh, Scotland. Noting that the overwhelming majority of R/S-health studies have been conducted in North America, she highlights findings that have received especially high levels of cross-cultural replication, offers snapshots of how R/S-health issues can manifest themselves in various cultures worldwide, especially in the developing world, and discusses the salience of religion and spirituality to the work of international public health organizations, such as the World Health Organization. In the book's final chapter, the editor offers additional overall reflections and suggestions for future directions, advocating positive collaboration, and asserting that even benignly ignoring religion and spirituality is not an acceptable option.

It is the earnest hope of this volume's editor, and surely of most or all of its numerous other contributors, that the importance of religious and spiritual factors for the field of public health will soon become more widely recognized, acknowledged, and acted upon in appropriate ways in education, research and practice. Importantly, the interconnected nature of education, research, and practice means that virtually every reader of this book, whether a public health researcher, academic, practitioner, or student, is in a position to contribute. Each of us can help guide R/S factors to their proper roles in public health by integrating them in appropriate ways into our own research, teaching, practice, conversations with colleagues, and conference presentations. Spiritual and religious factors are not the whole of public health, but they represent an enduring, important, and cross-cutting subfield, a distinctive and powerful perspective, and an enormous and growing research literature that has been hidden in plain sight for too long. We hope that each reader will find sufficient resources in this volume to address these powerful factors in ways optimal for the reader's own context, enabling the reader to make a contribution that is both global and local in its value.

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