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In God We Trust: Community and Immunity in American Religions during COVID-19

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Abstract: From the systemic issues of race and class division to political partisanship and religious identity, the pandemic has affected many aspects of American social and political life. I interrogate the role that religions have played in communal identity-making during the pandemic, and how such identities shaped ideological responses, particularly in the US, stymying public health efforts to stop, or at least significantly slow, the spread of COVID-19. Drawing from Gabriel Garcia Marquez's *Love in the Time of Cholera* as a historical case study, I use Garcia Marquez's depiction of religion's identity-making power during the cholera pandemic depicted in the novel as a comparison by which to understand current experiences of white Evangelical Christians in America during the current COVID-19 pandemic, particularly those who reject risk-minimizing practices such as mask wearing, quarantining, and vaccination. Drawing both from representations of Roberto Esposito's theory of immunity and community, and from Lauren Berlant's concept of "cruel optimism", as well as sociological understandings of religion and identity, I argue that the boundary-making practices of religion and of communal and national identity are related to the complex and often contradictory set of moral practices that led many white Evangelicals to disregard public health policies surrounding COVID-19. A concurrent analysis of Garcia Marquez's novel and of current events will allow me to explore this phenomenon, as Lauren Berlant would put it, both through the historically affective aesthetic and through the affective present.

Keywords: COVID-19; white Evangelical Christianity; vaccines; religious identity; public health policy; community; immunity; *Love in the Time of Cholera*

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1. Introduction

The COVID-19 pandemic has both highlighted and exacerbated the sharp divides in America that have been present since the country's foundation. From the systemic issues of race and class division to the urban/rural divide, political partisanship, and religious identity, the pandemic affected many aspects of American social and political life. Joining scholars such as Sandro Galea who have interrogated the social and systemic forces that shape health in America, I aim to question the role that religions played and continue to play in communal identity-making during the pandemic, and how such identities, particularly in the US, shaped both conscious and unconscious ideological responses, stymying public health efforts to significantly slow the spread of COVID-19. While individuals from the full range of representative belief systems and identities refused vaccination for myriad reasons, the group that did so most prevalently, as detailed later in this article, was that of white Evangelical Christians (Religious Identities and the Race Against the Virus: American Attitudes on Vaccination Mandates and Religious Exemptions (Wave 3) 2021). Many, but certainly not all, of the white Evangelical Christians who did receive vaccines remained silent about their vaccine status, while publicly espousing or passively assenting to anti-vax rhetoric. While of course white Evangelical Christianity is not a monolith, a significant percentage of the population of white Evangelical Christians did demonstrate anti-vax and anti-mask stances, and often refusing to socially distance. Not all white Evangelical Christians adopt an anti-vaccination stance, and many did, in fact, follow the public health

guidelines put in place by the CDC (Religious Identities and the Race Against the Virus: American Attitudes on Vaccination Mandates and Religious Exemptions (Wave 3) 2021; The Coronavirus Pandemic's Impact on Religious Life n.d.), but they are not who I am writing about in this article.

By looking at both the sociological data collected across the pandemic and the multi-faceted nature of identity's role in decision making, this article identifies and ponders the power of religion as a cultural force. I posit that the boundary-making practices of religion and of communal and national identity created the complex and often contradictory set of moral practices that led many white Evangelicals to disregard public health policies surrounding COVID-19, despite the presence of radically different attitudes and responses from individuals who are representative of other strands of American Christianity and other religions. In particular, religions serve as the basis for a cultural community which in turn influences political views and enables in-group thinking. This groupish behavior as seen in white Evangelical Christians is then used to advance partisanship between religion and science as well as left- and right-wing political parties. It is this partisan thinking that led many to behaviors counter to reasonable health indicators.

Before exploring religious identity-making in relation to the pandemic, I would first like to account for the complex nature of a public health response and communicable disease. There is no one thing alone that caused the United States' devastating response to COVID-19 (Lewis 2021; Galea 2022; Simmons-Duffin 2022; Dias and Graham 2021; Religious Identities and the Race Against the Virus: American Attitudes on Vaccination Mandates and Religious Exemptions (Wave 3) 2021; The Coronavirus Pandemic's Impact on Religious Life n.d.). Rather, "health is the state of not being sick to begin with, and it is shaped by social, economic, environmental, and political forces" (Galea 2022, p. xvi). As public health scholar Sandro Galea (2022) points out, the American health care system has developed as a response to acute care illness, not as a preemptive public health system that seeks to ensure the health of Americans. Further, the decentralized nature of public health programs in the United States led to 50 states adopting as many approaches to stop the spread. America entered the pandemic with flawed systems that made health a commodity to be distributed unequally, with people of color and those of lower socioeconomic status least likely to have access to the resources necessary to live a healthy life. The pandemic, thus, struck those communities hardest.

Why then, one might ask, have I chosen to focus on white Evangelical Christians in this paper? Disease does not obey boundaries, class, or the color divide—public health means focusing on the health of all. If one group of people decides against following public health guidelines, especially in the case of a communicable disease such as COVID-19, it could put everyone at risk. While this is not unique to white Evangelical Christians, the fact remains that they were the most likely of any group to view COVID-19 as a non-threat, or worse, as not being real, and they were more likely to identify their faith as reasoning for these views (Dias and Graham 2021; Religious Identities and the Race Against the Virus: American Attitudes on Vaccination Mandates and Religious Exemptions (Wave 3) 2021). This noted, understanding why certain people choose to ignore these guidelines can further our knowledge on how to reach such communities and prevent the spread of future pandemics. Religion in America is positioned as both a social and a political force, and is therefore an especially rich area of study for COVID-19 response and public health.

As a complex and varied set of practices, religions have had both positive and negative effects for individuals during the pandemic. On the whole, individuals who prayed about COVID-19 were more likely to participate in risk-mitigating practices such as mask wearing—with the notable exception of white Evangelical Christians with belief in religious nationalism (Corcoran et al. 2022; Perry et al. 2020). Belonging to a community with a durable and tested shared religious identity provides a support system, with many individuals turning to religious leaders and other congregation members for guidance and care (Keshet and Liberman 2014; Krause et al. 2002). For example, in many Jewish communities, the sense of belonging provided by religion played an important role in

building resiliency during quarantine (Frei-Landau 2020). Malaysian healthcare workers who practiced religion were less likely to exhibit symptoms of anxiety and depression throughout the pandemic (Chow et al. 2021). Likewise, research has shown that in America, religion has provided comfort in the face of growing anxiety throughout the pandemic. Yet, this same comfort also made a uniform public health response difficult in the United States, as many individuals and their communities were led to believe that COVID-19 might not be a threat or as great a threat as some surmised (Schnabel and Schieman 2022). Individuals with white Evangelical Christianity as an identity marker were significantly less likely to comply with public health policies (Funk and Gramlich 2021; Jackson 2021; Religious Identities and the Race Against the Virus: American Attitudes on Vaccination Mandates and Religious Exemptions (Wave 3) 2021; Schnabel and Schieman 2022; The Coronavirus Pandemic's Impact on Religious Life n.d.). Religious nationalism in the United States affected government policy to forgo mandated public health measures, with Evangelical Protestant officials more likely to be exposed to and align with religious nationalist ideals (Adler et al. 2021).

While much research has been done on the role of religions in shaping health practices during the COVID-19 pandemic, the primary methodology to study their response to the pandemic has been survey based with quantitative analysis of the results (Religious Identities and the Race Against the Virus: American Attitudes on Vaccination Mandates and Religious Exemptions (Wave 3) 2021; Chow et al. 2021). Though this research is helpful in determining the role of religious identity during COVID-19, it does not adequately address the potential reasoning or justifications behind these ideological responses, nor does it identify and explain different models of religious pandemic response. My exploration of pandemic response through the lenses of Lauren Berlant's concept of "cruel optimism" and Roberto Esposito's delineation of the relationship between community and immunity offers one explanation of the ideological responses, while my close reading of *Love in the Time of Cholera* provides a different response model.

Berlant's cruel optimism conceptually explains attachments, or objects of desire, to which the subject attributes a "cluster of promises" (Berlant 2011). The belief, or optimism, in the attachment is that it will make possible a dream or a goal the subject desires. The cruelty of such a bargain surfaces when the desire is either not fulfillable or, when fulfilled, is harmful to the subject (Berlant 2011). The communal identity associated with Evangelical Christianity became one such attachment.

To better understand how community affected immunity, and vice versa, I turn to Esposito. While I will be using Esposito's philosophy to discuss literal viral immunity, it is important to note that he is conceptualizing immunity in the abstract as a general term. Tracing the etymology of the words, Esposito suggests that community and immunity are related in that communities are bound by common laws, and immunity places individuals outside of that structure. To be immune, then, in an abstract sense, is to isolate oneself from a community. This concept can be seen not just in medical discourse, but in legal and political discourses as well. For example, the person who testifies in exchange for not being charged with a crime, or the person who holds a nationalist anti-immigrant stance, respectively. Esposito (2013) also posits a solution—a reframing of community as something that cannot exist without first achieving immunity—which I will return to in a close reading of *Love in the Time of Cholera*, immunity being the key that reopens the borders of the individual.

To better reach a multiplicity of populations in the responses to health crises, we must understand the roles religions play in individual and group decision making. Drawing from Gabriel Garcia Marquez's *Love in the Time of Cholera* as a historical case study, I compare Garcia Marquez's depiction of religion's identity-making power during the cholera pandemic at the end of the 19th century to current experiences of white Evangelical Christians in America during COVID-19, particularly those who refused to mask up, quarantine, and/or receive vaccination. Because the focus of *Love in the Time of Cholera* is, as the title suggests, on interpersonal relationships with the cholera pandemic as a backdrop, it gives

unique insight into religious identity, community, and health. Garcia Marquez's novel suggests the possibility of a less partisan relationship between science and religion and allows us to envision what might be if we can highlight shared sets of values rather than focusing on difference.

2. American Identity and Religions in COVID-19

In the era of COVID-19, religious identity has taken the fore in public debates on risk-minimizing practices surrounding the pandemic. This stems from the paradoxical relationship between community and immunity that emerged from overlapping national, political, and religious identities. In America, the overwhelming view is that political decisions are made secularly and are empirically grounded, established by listening to the data points provided by scientists and responding to them appropriately. However, not every American citizen has the same relationship with scientific information, as many distrust science whether due to religious belief or other cultural ideologies. This complication is exacerbated by the reality that science communication is constantly providing us with new data—data which can be difficult to decipher for the layperson (Chan 2018; Dias and Graham 2021; Glass 2019; Olagoke et al. 2021; Payir et al. 2021). As Esposito, paraphrasing philosopher-anthropologist Arnold Gehlen, states, "In a situation of excessive environmental impact and pressures, institutions are charged with exonerating man from the weight with which the contingency of events saddles him. This requires a kind of 'plasticity,' or a capacity to adapt to a given situation so as not to expose the individual to an unbearable conflict" (Esposito 2013, p. 40). If one institution—say, one of science or reason-based political policy—fails to adapt, and an individual finds the divide between lived experience and policy (or belief and policy) too great, they will turn to an institution that better protects them from conflict. In the United States, we see this turn away from science and toward religion in the behavior of white Evangelical Christians (Plohl and Musil 2021). Such a response, very much a symptom of an ongoing distrust of the scientific community due to an in-group mentality and differing value systems, one that has essentially placed science and religion at odds with one another, dates back as far as the Scopes Trial in the 1920s (Evans 2013). The public trial pitted science against religion, sparking speeches such as "The Bible and its Enemies", and resulted in a decades-long debate about whether the Tennessee law banning the teaching of evolution in public schools was constitutional (Adams 2005). This ongoing moral debate regarding the history of evolution and current iterations around stem cell research and human cloning laid the groundwork for the evangelical response to COVID-19 by, as some believe, engraining distrust of science in the identity of Evangelical Christianity (Dias and Graham 2021). Further, as nation and religion are tightly bound in terms of identity, in-group members demonstrate political behaviors they perceive to match their own religious values—values which the current Republican party touts as foundational to their platform and traditionally "American" in nature (Glass 2019).

American national identity is founded, as many history textbooks would tell us, on religious freedom (or, perhaps more accurately, freedom for the particular religion of Puritanism). The first amendment of the Constitution expressly legalizes freedom of religion in the free exercise clause, and arguably the separation of church and state in the establishment clause, yet historically, these have been unevenly addressed by the Supreme Court. However, the upshot of both the constitutional recognition and establishment, as well as the attention to their construal over two and a half centuries, is that religious belief and cultural expressions have solidified themselves in the fabric of American culture to a degree not matched by other existing democracies or industrialized societies. The tie between religion and American identity is also evidenced in more recent history. For example, in the 1950s the Census Bureau debated for nearly a decade on whether religious affiliation should be included as a census question (Schultz 2006). On one side of the census debate was the recognition of the evolving presence of religious pluralism in the culture; on the other, a number of Protestant Christians who feared plurality was a façade—that the real agenda was to de-Protestantize America (Schultz 2006).

In the mind of these Christians, the fear of pluralism was justified, and highlights a similar concern that exists among various groups today, in that religious identity and national identity, alike, are concerned with the formation (or disintegration) of boundaries. These boundaries play a role in the formation of communities, and "Members of a community are such if and because they are bound by a common law" (Esposito 2013, p. 14). For a nation, such boundaries are drawn on maps, and by the laws instituted through political regimes. In the case of religions, this "common law" is that of their particular belief set defined as a shared "method of valuing" (Pecorino 2001). However, religion as an identity-making practice is not as simple as volitional membership in a group. As anthropologist Clifford Geertz argues, religion is a cultural system; it "provides a blueprint" by which individuals can shape their lives. In other words, religion provides structure and meaning through which individuals shape their reality, contributing to the structure of religions reciprocally (Geertz 1993, pp. 92–93). Religion's status as a cultural system makes religion a powerful factor in other aspects of identity, particularly political ideology. In a call to attend to Western religions' role in sociological phenomenon, Glass states, "As a social "glue" that allowed diverse individuals to see common purpose and affiliation, religion both defined a set of social values to be realized through social life and norms to be followed to achieve those values. The downside, however, of any bonding ideology is the in-group mentality it creates and the prejudice it incites against other value systems and behaviors, producing conflict both internally and externally with other social groups" (Glass 2019, p. 10). In the United States, as previously mentioned, religion and national identity are historically bound to one another. The in-groups created often run along these identity lines, and the values, or "common laws", which define them. Yet, researchers such as Glass show that political identity should also be factored into this equation. Rather than secularity determining political law, religions play a major factor in political ideology.

As debates about mask and vaccine mandates arose, COVID-19 became not just an issue of public health, but a political issue steeped in religious and nationalist ideals. Religion often influenced the pandemic response, not just of the American people, but of government officials (Adler et al. 2021). It is difficult to separate the threads of politics, nation, and religions in behavior, as identity is a complex formation of many facets of an individual's life. Whereas previous debates between Evangelical Christians and scientific reasoning have been relatively harmless in terms of immediate and widespread health outcomes, the pandemic posed a different kind of problem, one with direct consequences both inside and outside the religious community. Despite the scientific data that show the efficacy of quarantine, vaccination, and mask wearing in preventing the spread of COVID-19, white Evangelical Christians have been resistant to comply with these risk minimizing practices.

We can see this resistance in the reported numbers of vaccine refusers across identity groups. Data collected from November of 2021 by PRRI show that, at 25%, the percentage of white Evangelical Christians who refuse to get vaccinated again COVID-19 was higher than that of any other religion (Religious Identities and the Race Against the Virus: American Attitudes on Vaccination Mandates and Religious Exemptions (Wave 3) 2021). Other research has shown the difference to be even greater, with the percentage of vaccine refusers among white Evangelical Christians as high as 40% (Funk and Gramlich 2021). Moreover, only 63% of white Evangelical Christians reported that they always wear a mask—significantly less than other religious identity groups in the United States—while 75% believed that churches should be allowed to hold in-person services (The Coronavirus Pandemic's Impact on Religious Life n.d.). While mask-wearing policies have lifted as the vaccine proves effective and COVID-19 becomes endemic rather than a pandemic, a lack of mask wearing during in-person events at the time this data was collected turned every service into a potential super-spreader event. In the crisis time of COVID-19, such actions had dire consequences, the repercussions of which are still felt today. Many of the areas that experienced the highest infection rates also had a higher population of Evangelical

Christians, most likely due to the refusal to follow public health guidelines (Jenkins 2021; Gonzalez et al. 2021).

3. The Cruel Optimism of Religious Attachments: Immunity of Community

With the dangers presented by COVID-19, why then do white Evangelical Christians, in particular, continue to resist vaccination as a matter of principle? Lauren Berlant's idea of cruel optimism and Roberto Esposito's ideas on community and immunity are helpful in formulating a provisional and insightful response to this phenomenon. Religious identity in itself is not harmful, and in fact, is often beneficial in its community building. Rather, it is when religious identity cannot adapt in the face of crisis that the attachment becomes cruel. Embracing an identity that requires one to expose themselves to harmful situations, such as the increased potential of contracting a communicable and severe disease such as COVID-19, is clinging to an optimism that is cruel. In white Evangelical Christians, such attachment is rooted in, and exacerbated by, sociohistorical clashes between their theology and scientific findings. The presumed loss of the community in exchange for immunity is what thwarted many Evangelical Christians from following the risk-minimizing guidelines put forth by the CDC. This common behavior was propagated by two different means, or two different shared laws. First, the allegiance to a respected leader such as a pastor may result in the decision to respect the relationship and prescriptions given at the expense of other potential choices. In the case of the COVID-19 pandemic, spiritual leaders became role models in behaviors that extend beyond faith. Second, an enactment of shared and specific religious beliefs motivated the rejection of masking and social distancing, and in the second and third years of the pandemic, the use of vaccines. The optimistic promises attributed to being an in-member of the white Evangelical Christian group, for many, led to the turn from science, which could arguably be explained by science's (and its spokespersons') failure to adapt and appeal to these shared values.

Let me turn to a hypothetical case study posed by Sandro Galea in his book, *The Contagion Next Time*, to further illustrate the turn from scientific to religious institutions. Galea presents the story of Jean, who grew up in an abusive home and found church to be a place of refuge—a place that spread a message of harmony and shared purpose among people. When COVID-19 struck, Jean continued to attend church with much of her congregation. Galea frames this story in terms of a hierarchy of perceived health needs of an individual; in Jean's case, the communal nature of church held more importance for her mental and spiritual health than the threat of COVID-19 held for her physical health (Galea 2022). While Galea's explanation of Jean's decision to continue going to church is certainly part of the story, the motivation to attend goes beyond a weighing of health needs. It also entails cruel optimism. While mental and spiritual health are indeed important, achieving this spiritual health did not need to come at the expense of incurring the potential risks to physical health. The attachment to the church as a life-changing space becomes cruel when risking a life-threatening communicable disease becomes the real cost of attending. Mental and, to an extent, spiritual health are moot points if one is dead. In Galea's case study, as well as in many actual churches, masking was uneven and social distancing guidelines were not followed. Rather than attempt to strike a balance between the new circumstances of COVID-19 and mental/spiritual health, many churches and white Evangelical Christians refused to adapt to meet both sets of needs.

They also used their religion as the justification for not taking risk-mitigating measures against the virus. In one New York Times interview, "Lauri Armstrong, a Bible-believing nutritionist outside of Dallas, said she did not need the vaccine because God designed the body to heal itself, if given the right nutrients. More than that, she said, 'It would be God's will if I am here or if I am not here'" (Dias and Graham 2021). The logic behind Armstrong's assertion is that God determines all, and would ultimately decide the fate of those exposed to COVID-19. Following this reasoning to its extreme conclusion, supporting and participating in risk-mitigating behaviors would go against God's will. It is worth noting that there are a number of white Evangelical Christians who were hospitalized with

COVID-19 and are now advocating publicly for the vaccine, with the argument that if God made COVID-19 he also made the vaccine. At the same time, those from this cohort who are not vocal about their beliefs maintain a low profile in public forums so as not to attract ridicule or engage in public debates. Yet, many espouse beliefs like Armstrong's, finding (or remaining a member of) a community of like-minded religious people. Yes, individuals who get vaccinated and wear a mask are one step closer to immunity, but in doing so they are "break[ing] the circuit of social circulation by placing himself or herself outside of it" (Esposito 2013, p. 59); in essence, they are trading their community for immunity. They are not just betraying their religious beliefs, but in doing so are also removing themselves from the community that shares their religious identity, a community to which they are attached, and which can fulfill the desire of redemption and eternal life. Though such individuals would be at less risk of losing their life to COVID-19, they often feel they are at a higher risk of losing the life they built within their community and the promises which they believe that community makes possible. While loss of community is not the language that many anti-vax and anti-maskers use when expressing their reasoning for their actions, which is often rather complex, we can trace back these behaviors to a base of in-group reasoning that stems from their religious affiliation.

Ironically, in avoiding the immunity that comes with preventive measures against COVID-19, white Evangelical Christians were simultaneously and inadvertently stymying the potential for community in the long term. Esposito suggests that for these individuals "The idea of immunity, which is needed for protecting our life, if carried past a certain threshold, winds up negating life. That is, immunity encages life such that not only is our freedom but also the very meaning of our individual and collective existence lost" (Esposito 2013, p. 61). This sentiment is reminiscent of the arguments against vaccination and mask wearing, along with the belief that mandating such behaviors is a violation of personal freedom which, for many who espouse this logic, is analogous to the integrity of their community and relationship to God. In the case of white Evangelical Christians, the threshold for determining which steps to take to increase safety or establish herd immunity, steps which would have the consequences of negating life-as-normal in evangelical communities during the COVID-19 pandemic, was lower than in many other religious communities, such as Catholicism.

Why might this be so? Stemming in part from the overlap between political and religious identity groups, many of the arguments for the WEC position are made in the name of religion, but mask a deep and abiding allegiance to a political ideology that may have little to do—historically or substantively—to commitments to Christian faith and morals. As an example, loving thy neighbor has been used since the earliest decades of Christianity as a nonnegotiable touchstone and framework to encourage actions on behalf of the neighbor. During COVID-19, getting vaccinated was often framed as an act of care for those who are at greatest risk of the disease. While loving thy neighbor is a Christian ideal, statistically evangelicals are the least likely of any denomination to appeal to this reasoning when it comes to vaccines (Religious Identities and the Race Against the Virus: American Attitudes on Vaccination Mandates and Religious Exemptions (Wave 3) 2021), and white Evangelical Republicans even more so (Jackson 2021). Yet, not masking or vaccinating and continuing to hold large in-person gatherings in prayer settings puts the entire community at risk. Without preventive measures, COVID-19 can quickly spread through a community and have serious consequences, including death. Paradoxically, in focusing on immunity rather than community in an unbalanced way, the community is endangered.

Yet, such paradoxical beliefs are not unusual in partisan thinking. As social psychologist Johnathan Haidt (2013) points out, humans are both selfish, focused on what benefits the individual, and groupish, focused on what benefits groups to which they belong. Decisions are made not based on reason alone, but on an emotional level as well. When groupish thought becomes polarized and partisan—as with religion and science, or with left and right political parties—it is our emotional response that kicks in first, especially when receiving information contradictory or harmful to the group. Rationalizing

such information releases dopamine, and as Haidt points out, "Like rats that cannot stop pressing a button, partisans may simply be unable to stop believing weird things. The partisan brain has been reinforced so many times for performing mental contortions that free it from unwanted beliefs" (Haidt 2013, p. 88). The rhetoric used in anti-mask debates is especially, and sometimes aggressively, partisan, positioning individual freedom to not mask against the tyranny of an oppressive government. Further, much of the rhetoric draws not just on political identity, but also on a Christian identity appealing to individual freedom as "God given rights" and holding politico-religious festivals such as Bards Fest, which featured several prominent Evangelical Christian speakers. It becomes easy for white Evangelical Christians to react groupishly, and justify not wearing masks as protecting collective existence, rather than interpreting this as a way to protect that very same ideal.

The imbalance and paradox in the COVID-19 response is not the fault of religion alone. Rather, white Evangelic Christians are caught in a double bind of neither religious nor scientific institutions adapting fully, as Esposito and Gehlen suggest is necessary, to relieve the burden placed on the individual. In the debate over vaccination, many Evangelical Christians cite the use of fetal stem cells acquired from an elective abortion as the reason they refuse vaccination. The development of the Johnson & Johnson vaccine did, in fact, use a cell line derived from a fetus aborted in 1985, while Moderna and Pfizer used the same cell line to confirm the viability of their vaccines (Schimelpfening 2021). Fetal cell lines are lab-developed stem cells that originated in fetal tissue, but do not contain actual fetal tissue. These cell lines are used in laboratory testing of the viability of many drugs, including common over-the-counter drugs, the usage of which is not opposed by white Evangelical Christians. Catholicism, whose teachings also oppose abortion, has, in contrast, adapted to the COVID-19 pandemic. Catholic religious leaders have publicly advocated for the vaccine, stating that it is morally sound to use any of the three vaccines approved by the FDA for use in the United States. Yet, leaders of the Evangelical Christian community continue to push back against vaccination and mask wearing on social media and television, while research has suggested that members of a religious community have a higher trust in such informal media sources (Olagoke et al. 2021). Even white Evangelical leaders who support vaccination are hesitant to speak out regarding the matter due to fear of alienating members of their congregation (Dias and Graham 2021).

On the other hand, clear communication of scientific concepts coupled with outreach and representation towards religious identity is where public health scientists were (and still are) lacking. From the Trump administration's downplaying of the seriousness of COVID-19, to the inconsistencies in messaging and personal compromises in integrity made by some health officials in order to maintain jobs and stability, to the decrease in CDC telebriefings during the Biden administration, public health officials, save for a couple of familiar faces, have not connected with the public, communicating primarily via text on the internet (Simmons-Duffin 2022). Rather than establishing a basis of trust between those most often in the public eye, (i.e., the professionals researching and acting on such research), and the peoples affected by those reactions (the population sheltering in place, glued to the television for any new information), those on whom we depended to fortify public trust dropped the ball. The nation was bombarded with conflicting messages and left to sift through dispassionate data and bureaucratic guidelines. Indeed, during COVID-19, science communication was marked by the speed at which circumstances changed. With rapidly unfolding new information regarding the spread of COVID-19, scientists took to Twitter to share data and information. Still, much of the communication regarding public health guidelines was too focused on data, and not enough on acknowledging the needs of the citizens that those guidelines affected (Galea 2022; Nabi 2021). For individuals who already have a distrust in scientific findings, sharing data alone is likely not going to suffice when asking them to make major lifestyle changes, even for a limited time. While scientific communication did adapt to the speed of the changing circumstances, and to the shift to social media as a major outlet for spreading awareness, it did not adapt enough to persuade those Evangelical Christians who were most likely to disregard risk-mitigating

practices. How can public health officials and scientists be more effective at reaching such individuals?

4. The Affective Present and the Historically Affective Aesthetic

To better understand the present pandemic situation, we need to look to the past. As Michael Lewis reveals in his interviews, scientists and public health officials woefully neglected historical research conducted on pandemic response in formulating public policy strategies in 2020 and beyond. Instead, the response to COVID-19 was slow, and the fear of a public shut-down delayed quarantine measures (Lewis 2021). It is clear from Lewis' presentation that a wealth of pandemic modeling and scientific research had been performed in the fields of epidemiology and public health. Despite showing efficacy in slowing or stopping the spread of past contagions, these insights and tools were ignored as options in the current crisis. Along with Lewis's anecdotal material, as well as studies on previous public health crises such as polio and AIDS to highlight the roles played by vigilance and intransigence in the face of epidemics, I suggest a turn toward literature as a means to ascertaining why such attitudes exist and how to effectively respond to them.

As a supplement to looking at scientific data and biographical accounts which do not always or readily address cultural factors that play into a public health response, we might also consult fictional narrative accounts as prospective entry points into how human beings might cope with pandemics, or indeed have coped with them in the past. An exemplification of this approach occurs with Gabriel Garcia Marquez's *Love in the Time of Cholera*, a novel which details both the woe and the response attendant to such a delicate navigation that is precipitated by a historic and disruptive health crisis. As I write this article, cases are spiking yet again in New York City, even as vaccines and boosters have been rolled out, the city has reopened, and COVID-19 is well on its way to becoming endemic rather than a pandemic. Any analysis I write, though removed from the constant sirens and high death tolls that marked the height of the pandemic, is therefore situated in what Lauren Berlant deems the affective present. She writes: "everyone lives the present intensely, from within a sense that their time, this time, is crisis time" (Berlant 2011, p. 57). Yet, the crisis we are facing and the challenges that accompany it are not new. They are historically situated and can thus be explored both historically and presently. It is for this reason that Garcia Marquez's novel becomes a key piece of my analysis. As Berlant points out, "all genres are distinguished by the affective contract they promise: by claiming that certain affects embed the historical in persons and persons in the historical in ways that only the aesthetic situation could really capture" (ibid., p. 66). Rather than exploring strictly sociological inquiries into pandemic response, by incorporating the fictional novel I can explore the atmosphere of the historical moment of the cholera pandemic to further understand the role that religious identity played then and now. Like Berlant, I will be interrogating this text for "patterns of adjustment" in order to illuminate collective action in the time of the pandemic (Berlant 2011, p. 9), which can then be used as a comparative tool into the present—a mediation of this crisis time.

Garcia Marquez paints a picture of Colombia during and after the fourth and fifth cholera pandemics. The novel, set in an unnamed Colombian city (presumed to be Cartagena) across the span of the 1870s to 1930s, tells the story of Florentino Ariza, Fermina Daza, and Dr. Juvenal Urbino as they navigate love, illness, and a changing world. Florentino and Fermina were young and in love, though Fermina's father disapproved, seeking a more illustrious name for his daughter than marrying the son of a freed slave born out of wedlock. After being forbidden to communicate with Florentino and taken on a trip to her mother's homeland by her father, Fermina begins to see love in a different light. Upon her return, she rejects Florentino, only later to fall in love with and marry the doctor Juvenal Urbino while Florentino waits for his true love to be widowed. In weaving the narrative of this love story, Garcia Marquez illustrates the intricate web of identities in the city, revealing how varied conceptualizations of the world, especially regarding health and medicine, are crashing into one another. However, in the novel, the varied views co-exist

with less tension than those regarding the COVID-19 pandemic. In fact, Dr. Urbino is able to reconcile the differences between religion and science and is thus accepted by the citizens and able to eliminate cholera outbreaks in the city.

Dr. Urbino's identity and how it is understood by those in the city he serves is key to his success in stopping the spread of cholera. Early on in the novel, regarding Urbino's differing view on the value of old age, the narrator states, "If he had not been what he was—in essence an old-style Christian—perhaps he would have agreed with Jeremiah de Saint-Amour" (Garcia Marquez 1988, p. 40). Even when serving in his role as doctor and friend to Saint-Amour, Urbino's religion is described at the fore of his identity. Importantly, here, Urbino is not just Christian, but described as "old-style", suggesting that he holds more traditional beliefs than others around him. Yet, unlike the rift between white Evangelical Christianity and modern science, his traditional beliefs do not interfere with his career as a medical professional, or vice versa. Instead, he is able to use his identity as a means to connect with the community and eventually institute life-saving public health policies and begin initiatives to transform the city into a safer space—one that does not readily breed and spread the cholera bacterium.

Still, Dr. Urbino's ideas were not accepted at first, neither by lay citizens nor by the doctors in the city. Having been trained in Europe, Urbino's suggestions to create more sanitary conditions were viewed as foreign intrusions that clashed with the traditional way of life in the city, and his way of thinking was scoffed at by fellow doctors, old and young alike. This tension comes to a head regarding the safety of the city's water supply. Locals believe that the mosquito larvae in the drinking cisterns were animes that cause inguinal hernias. Though Dr. Urbino was "aware of the scientific fallacy in these beliefs . . . they were so rooted in local superstition that many people opposed the mineral enrichment of the water in the cisterns for fear of destroying its ability to cause an honorable hernia" (Garcia Marquez 1988, p. 110). The local beliefs are established as a key aspect of the identity of those who live in the city. Though Urbino is bringing knowledge from Europe that can help prevent ill health in numerous ways, the belief that a scrotal hernia was a mark of honor outweighed the up-to-date foreign scientific knowledge brought home by the doctor. Local identity and belief systems trumped scientific knowledge and Urbino was judged harshly and viewed as an outsider, rather than part of the in-group.

Despite this initial setback, Dr. Urbino is able to overcome the division between his views and the beliefs of the other citizens when cholera threatens the city yet another time in the pandemic's long history. During the earlier pandemic, the city had enough bodies to fill the church crypts and close off church attendance. Rather than allow the pandemic to spread, Urbino, a cholera expert, implemented quarantine and minimized the outbreak. It was this success that led the community to believe "the sanitary rigor of Dr. Juvenal Urbino, more than the efficacy of his pronouncements, had made the miracle possible. From that time on . . . cholera was endemic not only in the city but along most of the Caribbean coast and the valley of the Magdalena, but it never again flared into an epidemic" (Garcia Marquez 1988, p. 115). The institutional flexibility that arose during the initial outbreak is what prevented a pandemic. Rather than stubbornly disregarding Urbino's suggestions, the institutions of medicine and military government adapted and abandoned outdated beliefs such as firing a canon to purify the air, and yet, religion still plays a role in the interpretation of events. The prevention of the pandemic is viewed as both a success for Urbino, but also as a miracle. The science-based policy making that Urbino instated is folded in with the belief systems that dominate the city.

During the outbreak of cholera, the damage of which Dr. Urbino did his best to minimize, mortality rates were kept in reasonable check and the city was able to go on with its daily routines mostly as usual, with the exception of some quarantines. Unlike previously when, "The air in the Cathedral grew thin with the vapors of badly sealed crypts, and its doors did not open again until three years later" (Garcia Marquez 1988, p. 111), the religious community was able to attend mass regularly and without pause. Without the immunity, or at least the risk-mitigating factors put in place by Dr. Urbino,

the religious community could not have congregated, at least not in the way that it had previously. The health of the community was put first, and arguably at a greater interruption than today when technology such as Zoom has risen to the challenge of maintaining a semblance of community while still sheltering in place. Thinking back to Esposito, reframing our understanding of immunity from something that separates individuals from the community to something that allows community to exist safely and uninterrupted is key to more effectively preventing the spread of communicable diseases. Not adapting to the circumstances that diseases such as cholera or COVID-19 present only puts community at risk for the long term, whereas immediate adjustments that protect individuals enable the ongoing existence of the community. As we see evidenced for Catholicism in *Love in the Time of Cholera*, the medical science that informs public health policies is not *necessarily* a threat to the religious beliefs of evangelicals but rather something that could help preserve that community.

Even when the text echoes the arguments of white Evangelical Christians today, Garcia Marquez creates a sense of coexistence between religion and science rather than opposition. Like Lauri Armstrong, who believes that God's will is playing out with COVID-19, in Garcia Marquez's narrative cholera was also viewed by some as an act of God. While on a trip, after her husband all but eliminated cholera in her city, Fermina sees the bodies of people who died of cholera and remarks that they appear different than those she had seen in the past. An officer responds, "That is true . . . Even God improves his methods" (Garcia Marquez 1988, p. 252). The speed and efficiency with which cholera killed was viewed as an act of God. However, scientific approaches to containing outbreaks were able to be implemented, including quarantining infected individuals. Rather than viewing necessary preventive measures as antithetical to their religion—as many white Evangelical Christians did—the characters in the novel saw them as miraculous, as though God's will worked through Dr. Urbino's new approaches to medicine and public health.

Furthermore, medical and religious habits are often described together through the character of Urbino, suggesting that the two are inseparable pieces of his identity. Early in the novel, his routine is described as the following: "He would spend an hour in his study preparing for the class in general clinical medicine that he taught at the Medical School every morning, Monday through Saturday, at eight o'clock, until the day before his death . . . After class it was rare for him not to have an appointment related to his civic initiatives, or his Catholic service" (Garcia Marquez 1988, pp. 8–9). The nearness regarding the discussion of Urbino's Catholic religion with his medical career and his duty to the city in which he lives suggests that the strong ties he holds with both religion and science are not an anomaly, but rather something that permeates the rest of the local culture. As Berlant might suggest, Garcia Marquez is building a sense of unity between religion and science, a unity that may seem entirely alien to someone living in the present-day United States where the two are positioned as opposing forces. Dr. Urbino's routine is not a private affair, but rather something publicly known and related to his work in the community. He hides neither his medical training nor his faith, and as such, is not ostracized for either.

5. Unity Protects Community

Unity in public health response and the buy-in of the community are both needed to protect that community. In the present situation in which we find ourselves in the US, it is necessary to work creatively, like Urbino in the novel does, in order to bridge the divide between the communities of white Evangelical Christians who continue to reject the efficacy of policies and tools for fighting COVID-19 and the growing public who work with scientific tools and public health policy to reduce risk and death. As religion and science are so often framed as opposing systems in the United States, it may seem daunting, or even impossible, to reconcile the two. Some may argue that by increasing the visibility of religious identity in science, policy makers will turn to religious mores more often than scientific reasoning as the basis for their policy choices. Others may be concerned that scientists who affiliate themselves publicly with a religion would lose credibility, despite research that has shown

that highlighting medical professionals' religious identities increases trust by religious individuals least likely to get vaccinated (Chu et al. 2021). This is not to suggest that science pander to religious belief, or vice versa. Rather, by acknowledging the presence and effect of both institutions upon each other and finding common ground through honest and open dialogue without the interference of partisan politics, both might be able to adapt and better serve the general population.

Appealing to general religious values such as loving thy neighbor may not be enough to sway some individuals, including large swaths of WECs, toward vaccination. The change in communication needs to be more holistic. If the institution that is appealing to a value is perceived as not sharing that value, such an appeal will ultimately fall short. Instead, a shared set of values needs to be established and shared at both a public and individual level. A 2005 survey found that 89.5% of American doctors identify as religious, or with a particular religion, 38.8% of them identifying as Protestant. Furthermore, 58% of those doctors who identified themselves as religious said their religious beliefs inform their treatment of patients (Curlin et al. 2005). While increasing transparency is a long and difficult process and not without potential drawbacks, it is most likely to help us attain our short terms goals of containing COVID-19 and our aspiration of bridging the divide between public health policy informed by science and religious groups such as white Evangelic Christians. Health practitioners and officials who practice minoritized religions in the United States—religions that do not have as prominent a voice in contemporary American political discourse—may feel less comfortable in disclosing their religious identity. For members of already stigmatized communities within academia, science, and the nation, self-disclosure poses the risk of further discrimination, though further research would have to be done on outing oneself as a believer in a minority faith. In the case of white Evangelical Christians, whose beliefs are represented in mainstream political movements, transparency of health care professionals who identify as such could help to bolster the response of their religious community and encourage them to follow guidelines.

Beyond the self-identification of individual doctors, public health campaigns that feature experts with a variety of identities, including various faiths, will reach a wider public. This will also normalize a relationship between science and religion and bolster support of religious leaders who might also encourage behaviors beneficial to public health. The divide between religion and science in the United States is not as polarized as the current COVID-19 crisis and its politicization might lead us to believe. However, the communication of the connection between the two institutions is lacking, and when considering the overlap and interplay of additional facets of identity, such as political affiliation, the divide seems even greater. If public health campaigns shift from the tactic of targeting segmented portions of the population and focus on depicting common values between health, science and religious institutions, it could lead to less polarization, encouraging more of the American population to follow public health guidelines (Chittamuru et al. 2020).

6. Conclusions

Religious identity is an influential piece of culture knit inextricably into the fabric of national identity, which itself is indelibly tied to religious identity. As such, the cultural system of religions holds sway over much of American life. Thus, it has historically and continues to influence the behaviors of Americans currently. The communal identity of white Evangelical Christians proved to hinder their adoption of risk-mitigating behaviors during the COVID-19 pandemic. Currently, while much quantitative research has been done in the form of surveys that identify white Evangelical Christians as the group least likely to receive the COVID-19 vaccine, there does not seem to be a critical mass of primarily qualitative research that compiles their narratives regarding resistance. My inspiration draws from news interviews of such individuals. Furthermore, while there has been research on anti-vax rhetoric, the focus tends to be on the messages targeting specific groups, rather than on the beliefs and responses of those groups' members (Billauer 2022). It would be fruitful, as others have suggested, to explore the reasons and discourse behind

the resistance of white Evangelic Christian individuals to risking minimizing public health practices during COVID-19 in a wider variety of ways (Mylan and Hardman 2021). While Esposito's philosophy and Berlant's concept of cruel optimism are not the only lenses through which this phenomenon can be understood, they do provide insights that can be applied not just to religious identity, but other aspects of identity as well, reflecting the complex cultural systems that influence individual beliefs. Berlant's theory also provides a framework through which analysis can move from the present into the past through cultural texts such as Garcia Marquez's novel. It is this historic turn that gives cultural and behavioral insight beyond the quantitative analysis of a survey response. Yet, historical insight can only go so far, and future inquiry should continue to think through current and future pandemic responses in light of the past.

Despite the risk to their own well-being, as the pandemic became politicized, many white Evangelical Christians drew on their communal identity as an exclusive source of motivation and knowledge and thus rejected the recommendations of public health scientists and doctors to mask up and get vaccinated. However, health science and religious identity do not necessarily need to be at odds, and examining how tensions between the two have been resolved in the past can provide us a hopeful model for the future. As Garcia Marquez depicted and as is reflected in my analysis of *Love in the Time of Cholera*, the focus should be on the commonalities between medicine and religion rather than on the differences. As evidenced in the character of Dr. Urbino, medicine and religions can coexist in harmony and even strengthen each other. If we find a way to tamp down the partisanship and create a space for open dialogue between the scientific community and those skeptical because of their faith, perhaps then we will be ready for, to channel Galea, the contagion next time.

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