Spiritual, Religious, and Faith-Based Practices in Chronicity

An Exploration of Mental Wellness in Global Context

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Chapter 1

Chronicity, mental wellness, and spirituality

An introduction

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1 Chronicity, mental wellness, and spirituality

An introduction

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Introduction

This book came into being by listening to stories of research participants living with chronic illness. Spirituality and religion, and in that context faith, emerged in the lives of many individuals as an enduring and unavoidable narrative. While this thread was evident in the lives of those affected by chronic illness, it also became clear that service provider narratives demonstrated a gap in their training, institutional support, or overall awareness when working professionally with clients' spiritual, religious, or faith-based practices and queries. This recognition led us as co-editors, each independently in our own work, to see that there was a gap in the literature concerning the knowledge and lessons learned about more effectively integrating discussions of spirituality and religion into service provision, in particular on the topic of chronic illness. As a start, our scoping review was published in 2017, exploring intersections between service provision, chronic illness, and spirituality or religion (Roger and Hatala 2017).

This exciting new collection is a robust addition to the current literature in the area, which has been scant in addressing the often-charged issue of spirituality and religion, one that is increasingly relevant for many global communities. Authors describe evidence-based, empirical research investigating participants' experiences of mental wellness in the context of spirituality, religion, and faith, widely defined; they represent dynamic and diverse views and perspectives from around the globe, including research conducted in rural and urban spaces. The chapters explore spirituality and religion in a way that does not presuppose benefits or pitfalls, but rather considers how people explore their own day-to-day practices and clinical work in the context of chronicity. Nor are the chapters designed to place value on any specific type of faith, religion, or spiritual practice; rather, they are included here because they focus on people's lived experiences, attending to both social and individual, structural, and existential contexts (Roger and Hatala 2017).

While the chapters could have been grouped by conceptual themes (e.g., land and space, mind, and wellness), grouping them by region was another consideration (e.g., North America, Africa, Europe), as was grouping them by stated chronic illness or religious affiliation (e.g., Christianity, Islam). In the end, we eliminated grouping the chapters with the agreement that this approach would simplify or

reduce the richness of the findings. As such, we argue that the themes of living with chronic illness and working with those who do invite wellness and spirituality to mirror each other regardless of the type of condition, faith base, or region in which the studies have taken place. The unifying principle is that each of the authors explores: the apparent role of spirituality and religion in shaping mental wellness; the practices described by participants associated with unique places, cultures, and contexts; the participants' reflections on health and well-being, alongside their hopes for recovery and healing, all of which endure throughout the collection. The authors' research findings stand on their own, despite these characteristic variations. In an effort to allow the multiplicity of participant experiences to speak for themselves, this collection is grounded in a mandate to uncover in an empirical or evidence-based manner how spirituality and religion emerged, both for those living with chronic conditions and for those who are care professionals and health providers offering services to them.

As these chapters demonstrate, individuals come together at times in formal and organized institutions (e.g., hospitals), and at other times, in less formal community settings and rural spaces, to share in and produce opportunities for strengthening the spirit and mental wellness, and the possibility of physical healing and resilience. Some accounts reveal the tensions that exist between service providers and their training, as they consider their clients within institutions they inhabit and the affiliated professional mandates and policies, and as they undertake the daily work of care and caring. The tensions between service provision, training and skills, institutional policy, and participants' needs are real here. These findings foreground, in detail, the complexity of accepting spirituality and religion as powerful forces in the lives of those depicted, people living with diverse chronic conditions. Other accounts reveal the commitment of professionals living in specific faith-based communities and their efforts to develop pathways to healing and wellness, comforting practices, and new coping strategies that re-direct or re-interpret experiences of illness and pain. In some cases, authors reveal the use of a spirit world or archetypes as a healing strategy. Recovery emerges as part of an important tonal landscape in which the fugal counterpoint between living with mental illness and using religion or spirituality towards wellness is not just a single voice but a choir. Most often, the authors describe how spirituality includes deepening a sense of meaning-making and purpose for their participants despite their suffering with chronic illness or helping those who do towards recovery or new definitions of wellness (i.e., being "well" despite living with chronic illness). Prayer in solitude or together in community, reading from meaningful texts, or learning to be a "good ancestor" are each an example of strategies revealed that aim to move participants towards transformation, healing, and self-defined wellness.

This inter- and transdisciplinary collection includes contributions from health care, the humanities, medical anthropology, and social sciences. We take as our theoretical point of departure the phenomenological and hermeneutic meaning-making traditions and share a concern for the manifold struggles that abound amidst the management of chronic conditions. In so doing, this collection makes a substantive contribution to the role of spirituality and faith in health and wellness,

with a focus on the personal lived practices of spirituality and religion in contexts of chronicity. The main themes include an exploration of how spirituality and faith-based practices can support people (or not) as they live with(in) chronic conditions of various kinds.

We include authors from around the globe who explore how specific geographic spaces or unique places, including Indigenous notions of “land” or alternatively religious pilgrimage sites, are central to the practices and meanings associated with religious, spiritual, or faith-based striving amidst chronicity. Sacred spaces become central in some of the chapters, where hope and transformation are linked to healing, practicing, and simply being in those spaces. There, the space itself becomes a focal point for the manifestation of spiritual practice and hope towards some kind of new found wellness. As a result, it offers some form of amelioration amidst chronicity. Community emerges as highly relevant in many of these land-based spaces and indicates an interpersonal site for exploration of the connection between faith-based practices and how these might shape interpersonal domains of social suffering in community. Examples include authors who explore histories of colonization or people who otherwise live with profound stigma due to mental illness in mainstream society but feel valued and accepted in these communities and spaces. The chapters demonstrate a great diversity in existing mental wellness and health concerns and cultural contexts through global problems. The authors explore cultural approaches that shape ideas about spirituality, religion, health, and wellness in new ways, spaces, and contexts that inform coping strategies, forms of resistance, help-seeking practices, ideas for recovery, or self-care more broadly from a global perspective.

Set against the cornerstone of chronicity, the authors expand our understanding of how their participants live out their daily lives to promote wellness through, and sometimes despite, spirituality and religion. At times this involves a focus on spiritual entities and how these intersect with individual experiences of conditions that can shape a “sick” or “marginalized” role in society but also, how individual agency and performative notions of a wellness identity challenge discourses of illness, marginalization, or disability in such contexts. Sustaining a framework of chronicity assists in building a cohesive argument in favor of much needed further research in this area. This collection revitalizes the understanding that we live in a global context in which faith continues to play an important role, and religious and cultural variations exist and are becoming commonplace no matter where we live and work. All of this underscores the need to establish awareness, training, and tools for professionals working within their own communities. In all chapters, the authors strive to highlight how practitioners, either medical, social, or faith-based, are assisting those with various chronic conditions within health care settings, hospitals, and communities, including challenging “what works” within these settings and systems. This includes the exploration of what is most at stake for people who draw on faith or spirituality in their management of chronic conditions and those who support them but particularly also the moral contours of their daily experiences

(Kleinman and Hall-Clifford 2010). The collection brings to mind concerns in modern health care around “quality of care” and how recovery should and can look, including discourses around contradictory faith practices between “clients” and professionals and how such interactions are sometimes managed and negotiated on behalf of others both usefully and to their own detriment. The richness of these chapters invites further reflection and exploration of this evident gap in the literature.

Chronic illness as context

A key health crisis and social issue facing humanity today is the increasing burden of “chronic” conditions. While the context of the “chronic” condition is most well known as medical- and treatment-oriented, this collection reflects on chronicity beyond the diagnosis of chronic medical conditions (Manderson and Smith-Morris, 2010) and brings a critical lens to the exploration of daily experiences of various forms of chronic conditions. The emerging focus is one of mental wellness, although several conditions or contexts are referenced by our authors. As a framework for considering persistent forms of distress, chronicity draws together developed and developing countries, the global North and South, East or West, including all contemporary human populations, “uniting us in desires for improved prevention, treatment, and care” (Kleinman and Hall-Clifford 2010, 247). In this context, this collection explores spirituality and faith-based practices of mental wellness while people are living amidst conditions that might incur struggle and distress for themselves but also for their families, their communities, and those who care for them.

The contemporary emergence of chronic conditions as a dedicated area of international attention arises from multiple intersecting factors and social processes. In many parts of the world, medical science and technological innovations have allowed patients who endure significant health problems to live considerably longer than only a few decades prior. People living with (by way of example) heart disease, diabetes, amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), Parkinson’s disease (PD), tuberculosis (TB), many forms of cancer, and HIV/AIDS all have the potential to live relatively long and fulfilling lives today. The 2020–2021 pandemic, COVID-19, exacted a new narrative related to chronic illness and health and ongoing persistent forms of social or individual distress. From another vantage point, places around the globe mired with insistent poverty, wars, environmental devastation, and various forms of social suffering, precarity, structural violence, or oppression all shape another form of chronic condition or “crisis *as* context” (Vigh 2006). People come to endure and struggle against unjust social forces that can oppose and limit their agency and wellness in significant ways, which can also be heightened when living with chronic conditions considered to be medical. This increase in what we are framing as chronicity, in turn, creates a significant challenge for and places a significant burden on health care systems and helping professions of various kinds, in both professional and popular, home-based sectors (Mattingly, Gron and Meinert 2011). Along these lines, Kleinman

and Hall-Clifford (2010, 250) argued that there is inadequate attention on daily lived experiences of wellness among chronicity and that “chronic conditions and quality of care need to be included in our discourse and in our funding allocations in global health programming.”

Chronicity theory

The concept of chronicity first gained attention in a special issue of *Social Science and Medicine* in 1990. In his introduction to the issue on medical anthropology and chronic disease, Anselm Strauss (1990) drew attention to the social and cultural complexities of chronic diseases and their distinctiveness in different settings. Following this, Sue Estroff (1993) used chronicity to discuss her research on schizophrenia. Chronicity, according to Estroff, incorporated symbolic and meaning-centered processes, such as inter- and intrapersonal conflicts that stem from a struggle to reinstate and negotiate who “I am” in the face of persistent illness. With a focus on the meaning-centered aspects of illness experiences over time, chronicity here described both the identity-related and social changes that occur in a person’s life, particularly with respect to relationships and social roles (Estroff 1993). Manderson and Smith-Morris’s (2010) edited volume, *Chronic Conditions and Fluid States*, advanced chronicity theory by including studies from non-Western contexts. From its early use, chronicity was historically linked to Western societies where individualistic identities prevail, but it has more recently been applied cross-culturally to explore both chronic and infectious diseases, and here we refer to mental wellness as a key thread in our work. For instance, Good et al. (2010) reported that culturally specific models of psychosis etiology, spiritual beliefs, and family care in Yogyakarta, Indonesia help schizophrenia sufferers stabilize or recover from their symptoms, rather than experience the illness as a degenerative condition.

Today, chronicity helps draw attention to the fluctuations amidst challenging life circumstances over time. Chronic conditions are thus distinctive because they do not end; rather they become entangled in people’s work, families, and life stories. Chronic conditions impact everyday routines, functioning, and capability as people are forced to grapple with mortality and their human limitations as a part of their daily routines. Indeed, by advancing the notion of “chronic homework,” Mattingly, Gron, and Meinert (2011) drew our attention to the kind of cultural work that patients and families are expected to carry out in their home or “popular health sector” during the day-to-day management of their chronic conditions. These authors argue that such “low tech” social technologies – day-to-day strategies or the work of coping – have received minimal attention in the academic literature. These issues suggest we focus on the way people cope not through crisis but *in* crisis (Vigh 2006). Doing so will provide valuable insight into this increasingly important, and increasingly common, area of human life. The authors in this collection do this brilliantly, offering much richness and texture to their daily experiences and work in this area.

Spiritual, religious, and faith-based striving

Despite a wealth of concepts and research looking into the day-to-day experiences of people living with various chronic conditions, it is surprising to note that there is minimal research looking into how individuals creatively, and at times subtly, draw on aspects of their spiritual, religious, or faith-based practices to find strength and build meaning amidst their sometimes distressing experiences. This becomes an especially important area of focus in the current context of globally increasing chronic conditions (Roger and Hatala 2017) but also in the more pronounced and often charged conversations surrounding religious, spiritual, and faith-based practices around the globe, evidenced even more so through wider access to social media. Understanding this, it is immeasurably valuable to reference the work of Koenig et al. (2012), who notably found that religion and related beliefs and practices of spirituality can in fact have a protective impact on those living with mental disorders and distress.

Identified in our chapters are themes that deepen and explore these issues, including: the creation and recreation of complex networks of care based on sacred relationships; the immense efforts people make to be well despite local and global challenges; the varied resources they draw upon in creating new communities intertwined with their attempts to carry out wellness (Mattingly, Gron and Meinerdt 2011, 354). Cutting across many of these themes, we contend and our authors demonstrate that spiritual, religious, and faith-based strivings are approached in meaningful ways but from sometimes quite disparate perspectives present in different forms across diverse cultural contexts. Indeed, individuals living with various chronic conditions continue to seek out and utilize both faith-based, religious, and/or spiritual practices in order to cope with their illnesses and life circumstances and to promote or support a general, more positive view of health and wellness (Hank and Schaan 2008; Roger and Hatala 2017). However, as our authors also illustrate, these practices are embedded in complex interpersonal relations where stigma and ostracization from the mainstream can accompany pre-existing mental health concerns.

Pargament (2002) argued that the efficacy of spiritual variables depends on the kind of religious or spiritual practice, “the criteria of well-being, the person, the situations and social context, and the degree to which the various elements of religious life are well integrated into the person’s life” (169). These are all areas that the current collection of chapters, authored from around the globe, explore. Thus, just as chronicity research turns from the clinic to the home environment of patients’ day-to-day work, so too, we argue, must the spiritual and faith-based health literature follow to build knowledge of the daily spiritual and faith-based practices of health maintenance, primarily regarding mental wellness within global contexts. Because some research has identified spirituality as a key resource amidst chronic conditions in health care contexts (Ai et al. 2010; Büssing and Koenig 2010; Craig et al. 2006), this book is important for individuals, families, communities, and health care practitioners. Settings include private and public spheres and popular and professional sectors. Another focus is those

working closely with individuals to identify how to better utilize spiritual and faith-based resources to build mental wellness while living with and within chronic conditions. In this context, the idea that people living with chronic conditions can experience wellness, and furthermore that spirituality, religious, and faith-based practices may be supports towards wellness, may explore, problematize, and even challenge an increasingly medical approach to mental health and a medicalization of the popular health sector. This is not to ignore or excuse how religion can and has had negative impacts on individuals and communities; however, knowing and respecting this reality, this collection focuses on evidence and a strengths-based approach. The collection is exciting in its challenge for service providers in that it illustrates the convergence and possible contradictions regarding some institutionalized health care practices; at times, these authors challenge mainstream approaches to care and open the door for new ways of offering and providing services to those living with chronic illnesses.

Mental wellness

Mental wellness evolved as a key concept in each of the chapters. Framing mental wellness as important to this collection, its presence in the chapters was most often set against the *gestalt* of a more traditional notion of biomedical dualities, meaning that study findings revealed experiences of living with chronic conditions in more diverse ways than measuring individual poor health as illness. Goals of strong and resilient mental wellness, our authors reflect, co-exist despite living with chronic illness, but these need to be re-constructed and re-imagined in an ongoing way, something we note reflects the work of Charmaz (1983, 1991). Charmaz set the stage for future researchers to reconsider how people can and do live well with chronic illness. In her ground-breaking work, Charmaz addressed early on how individuals engage in reflection and transformation as they learn to live with the trajectories of chronic illness, defining wellness for themselves, and thinking of recovery beyond a medical approach to what is otherwise considered at-risk, poor health.

Mental wellness emerged as a constant theme alongside various individual and collective practices associated with a range of faith groups and types of chronic illness. Wellness as an idea gave voice to a holistic and generative, positive view of otherwise challenging daily experiences. These diverse chapters, therefore, outline how mental wellness goes beyond what individuals alone can strive for. They also posit that we shift our thinking towards broader notions of the value of spiritual, religious, or faith-based practices and resources supporting mental wellness; that we address the challenges of interacting with service providers who may not share those perspectives; and, even further, that we engage with multiple cultural discourses, diverse geographic landscapes, and community-oriented collective experiences. Mental wellness is not a solitary pursuit.

In this way, mental wellness displaces a deficit model of health or mental health where subtractions are made for measurable gaps in one's health, and throughout the book the chapter authors refuse to focus primarily (or at

all) on illness-oriented and medical diagnostic terms. As such, understanding chronicity as posited by Manderson and Smith-Morris (2010) means understanding the idea of mental wellness is also shaped by our surroundings, cultures, and histories (national and global) and – we mean this in the broadest sense – understanding the impacts of social determinants on our individual and global health through empirical research, of which this book represents a global diversity, and understanding that we do not always agree or share similar views on things. Certainly, mental wellness amidst chronicity is framed by our authors to include poverty/wealth or rural/urban dichotomies, designated spaces, and particular places of practice.

As suggested by Manderscheid et al. (2010), the terms “wellness” and “illness” have historically been placed on separate continuums, with the latter placed in tandem with terms such as “deficits,” “disability,” and “disorders.” Ideally, “good health” indicates not having any of those disease-oriented diagnoses, but as Saracci posits (1997), this is far from practical or realistic. Manderscheid et al. (2010) further argued that previous foci on diagnosis have since shifted to more person-centered foci, and they state, “wellness refers to the degree to which one feels positive and enthusiastic about life” (1). The evolution of the terms themselves over time indicates a shift in the narrative and landscape of what it means to be well, and wellness includes spiritual health for these participants. Mental health has become a more contemporary concern in the Western world, but so too have the stigma experienced by those living with mental health issues and the invisibility of their daily realities (Centre for Addiction and Mental Health, 2020). People can gain from the respectful recognition that emerges when one has a specific diagnosis, but simultaneously, recasting poor mental health within a deficit model can potentially deepen its related stigma and associated discrimination. Broadening our understanding of institutional systems and discourses surrounding “mental health” is a valid and current concern, and perhaps discussions of Global Mental Wellness, as we explore in the concluding chapter, can help.

The National Wellness Institute (2020) suggests, “wellness is a conscious, self-directed, evolving process ... encompassing spiritual well-being, [and it is] positive and affirming.” It posits the following six dimensions of wellness: emotional, occupational, physical, social intellectual, and spiritual. These dimensions are evident in each of the chapters, and it is worthy to note that while the Institute does not include “mental” as one of their dimensions, the Institute does include spirituality. These six dimensions also refer to personal endeavors, contextual influences, strategies, and outcomes, as does our collection. The overall gaps in the literature point to the need to find better ways to understand mental wellness through spiritual, religious, or faith-based practices in contexts of chronicity. Given the evidence and thoughtful discussion presented by our chapter authors, spirituality and religion must be addressed in this context in that each occupies a central position for many communities around the globe.

We want to make a special note here of the role of community in mental wellness, as it emerged in our chapters. According to Absolon (2010) and Health Canada (2015), wellness must also incorporate being an individual in

community with others. It became clear to us that all chapters reflected the invaluable role of community – relationships to friends, family, neighbors, social groups, and intentional collections of people that were able to share in the experience of trauma and suffering with the intention of healing. Being in community, and finally, hoping to be well in community, is empirically demonstrated in the diverse collection of chapters.

In departing from an explicit illness-good health dichotomy, this book offers further empirical discussion of the “fluid states” and more subtle ebb-and-flow narratives of striving for wellness amidst chronicity (Manderson and Smith-Morris 2010), not just physically but also mentally and spiritually, a life in which wellness is often self-defined and self-managed by those living with chronic illness. For example, our authors discuss the self as a way to house mental illness but not to identify with being ill. Illness can be seen as externalized, separate, and not core to one’s being. They also reflect on the journey itself, the path of transformation, rather than a single state that achieves wellness. Being on a path is both metaphoric and physical – moving on a tangible, real landscape while reviewing one’s movement in one’s inner state. Thus, “fluid states” becomes a very poignant framework for our collection. As well, our authors discuss service providers as they struggle to find strategies and language to better work with their clients and as clients struggle to sustain strategies and language to help service providers work with them. As Manderscheid et al. (2010) state, “wellness” incorporates ideas beyond living with illness to include subjective experiences of happiness, hope, and personal definitions of well-being. We would argue that this balance, including hope and joy, is in fact more common to the human experience where traditional notions of poor health and mental illness are not always separated from experiencing and seeking wellness. Maintaining mental wellness is the territory in which most people are situated throughout their lives, at one time or another, in their own families and communities.

Typically good health and poor health are on a measurable continuum, a path directly linked to cures and treatments; however, this book explores mental wellness as it is defined by internal and external geographies of the spirit, through journeys and transformation, through aspects of self-management in relationship to others and in community, through the hope for individual wellness, and through the ongoing practice of seeking joy even while living with suffering and pain and the possibility of no cure but still with the goal of overall good health and mental wellness.

Chapter content

Chapter 2 frames well the tensions between service providers, the institutions they work in, and the people they serve. Freitas, Ruas, and Nwora describe and compare the findings of two studies carried out in a Brazilian context with psychologists working in mental health services, and with chaplains working in different contexts, including those involving chronic mental illness. Twenty-eight professionals (13 psychologists and 15 chaplains) were interviewed in-

depth using a phenomenological approach to ascertain how they perceive the relationship between religiosity, spirituality, and mental health and illness, and how they address these issues when they arise in the context of mental health care. Freitas et al. analyze and discuss the convergences and divergences between their perceptions and experiences; they explore the implications arising from this for the training and formation of multidisciplinary teams for the care of chronic mental illness, with a special emphasis on the specific and complementary roles of psychologists and chaplains in both contexts. In the end, the chapter outlines considerations and implications for public mental health policies, considering that mental health services should be prepared to approach the various manners of expression of religiosity and spirituality and their roles in coping with mental illness and the recovery of health.

McGregor and McKinley, in Chapter 3, take us to Indigenous communities in eastern Canada. Among the most central teachings for the Anishinaabek is the understanding of having a *manidoowaadizi*, or spiritual-nature, experiencing a human or physical existence. The teachings continue to instruct that, in a holistic relationship of mind, body, emotion, and spirit, the spirit impacts the mind. This chapter explores this important ontological knowledge in order to articulate the importance of using local teachings to heal the spirit when the mind and brain are negatively impacted by colonization. During the ongoing era of colonization in Anishinaabek territory, various forms of violence, including the attempted destruction of local knowledge, were enacted on the Anishinaabek. The resulting increases in negative mental health outcomes continue to be treated using Western biomedical methods rather than valuing and applying Anishinaabek knowledge. In response, the authors move away from a biomedical construct that locates mental illness as a problem to be treated in the brain. Instead, drawing on teaching from Anishinaabek Knowledge Holders, they maintain a holistic, relational ontology to understand how the spirit is a key component in long-term mental health. Examples are drawn from the ongoing collaboration between the Health Centre at Whitefish River First Nation in Ontario, Canada and their non-Anishinaabek partners. The authors explore the importance of strength and relationship-based research and interventions to improve the quality of life for individuals and communities living with the impacts of colonization. The chapter also articulates an approach to community-based knowledge translation by detailing the process of an Anishinaabek knowledge holder (McGregor) working with a Western trained scholar (McKinley).

In Chapter 4, Moratz critically investigates discourses of modernization amidst experiences of chronic spirit possession, “mental illness,” and Qur’anic healing practices in Burao, Somaliland, Northwestern Somalia. The research was based on ethnographic fieldwork between January 2013 and March 2020, conducted with the local help of the University of Burao. Data were collected through participant observation in the general society and of religious healers, as well as two rounds of semi-structured interviews in 2014–15 and 2018, respectively, involving a total of 26 participants and 42 interviews. Other relevant materials, such as a book manuscript by a local healer, a locally made

movie, and several YouTube videos were also analyzed. This chapter argues that chronic possession experiences and healing practices are conceptualized as part of the modernization process in Somaliland society. In contrast to other research into spirit possession, the Somali experiences suggest that possession does not need to be designated as a traditional phenomenon but is often considered modern. Moratz outlines how Somali Islamic practice, as part of Somali culture, may be part of a larger modernization vision of the global Islamic movement. The chapter also proposes that embracing possession as a modern phenomenon offers new ways of treating underlying suffering, as the causes of suffering are externalized and personified.

In Chapter 5, Kurz situates research findings of healing from various forms of chronic illness based on a case study and builds on that while focusing on the Spiritist movement in urban environments of Brazil. Within the Brazilian Spiritist continuum, a veritable healing cooperation between health professionals, spirits, mediums, and clients constitutes a complementing space of medical and spiritual practices. Based on ethnographic field research in different regions of Brazil, this chapter explores practices and narratives regarding the spiritual aspects of illness, cure/healing, and well-being. It addresses the sphere of aesthetics both in the sense of sensory aspects of the healing experience as well as performative metacommunication in healthcare politics.

In Chapter 6, Goldingay, Dieppe, Warber, and Rahtz, explore healing, rather than curing of chronic health problems, at the Marian Catholic pilgrimage site of Lourdes in South West France. This is a multidisciplinary team (doctors and humanities scholars) that have been undertaking research in Lourdes for the past several years. Their interest is in well-being and healing, rather than the miraculous cures of disease, for which Lourdes is best known. Research methods are largely qualitative, including in-depth interviews and focus groups with a wide variety of pilgrims and visitors to Lourdes, as well as doctors, priests, and others who work there, novel visual research methods (asking people to draw pictures of their experiences), and ethnography. The authors obtained recorded interviews with 67 people, which have been transcribed, pictures from 19 participants, film recordings of two sick people describing their experiences, and a wealth of ethnographic material from the three visits made to collect data in Lourdes. They argue that whilst cures of diseases are rare, improvements in well-being and relief of symptoms from chronic illness are common. Many different factors contribute to the transformative changes that people experience in Lourdes, including spiritual or “noetic” moments, place, and nature, connecting with others, and the religious rituals that take place in Lourdes. This chapter concludes by stating that more research needs to be done on the ability of religious pilgrimage sites, such as Lourdes, to activate personal healing and facilitate relief of chronic symptoms, rather than on cures and that work of this sort can make an important contribution to the debate on how wellness might be improved.

Chapter 7 comes back to Canada with a discussion about sacred worldviews and spiritual practices of young Cree and Métis Indigenous Peoples. The chapter details 54 interviews with 36 youth that were partially drawn from two

Community-Based Participatory Research (CBPR) projects exploring Indigenous youth wellness within a mid-sized Canadian metropolitan city, Saskatoon, Saskatchewan. Globally, this context often involves intimate connections with land and nature that foster pathways for promoting mental health, resilience, and overall wellness. Drawing on chronicity theory to situate settler-colonialism as a persistent and relentless chronic condition of the body politic emerging through land dispossession, intergenerational trauma, racism, and structural violence, Morton, Bird-Naytowhow, and Hatala consider the role of anti-colonial and Indigenous perspectives that center positive transformations of Indigenous youth wellness identities within a contemporary urban context.

In Chapter 8, Remy-Fischler details an ethnography of Spiritual Peer-Support Networks' (SPSNs) community in the United Kingdom, encompassing organizations like Spiritual Crisis Network and Emerging Proud. SPSNs provide support for individuals who identify as having experienced a mental health and/or spiritual crisis. These crises range from what could be labelled psychotic episodes to mystical experiences and everything in between. SPSNs promote seeing these experiences on a spectrum, rather than as separate ontological categories. There is a growing body of literature on experiences of psychotic-like phenomena reported by clinical and non-clinical groups. These point towards a shift in diagnostic categories in favor of a psychotic continuum to better represent this diversity of experiences. Using a combination of narrative and affect theories, this chapter looks at how knowledge or *knowledges* are gained from lived experiences of crises but also from narratives interpreting these crises, re-shaping each other in looping effects. Furthermore, this study also explores the extent to which these knowledges are perceived to be beneficial or healing for individuals. The study includes participant observation in events, meetings, and peer-support groups as well as in-depth interviews with 20 members of the SPSN's community, mostly in the UK, from January to April 2019. Most participants had encountered psychiatric services, and all identified as having experienced at least one mental health and/or spiritual crisis. A thematic analysis was constructed primarily from narratives of SPSNs and individuals, whilst keeping in mind the emotions and affects imbued within these. Remy-Fischler discusses knowledges gained from narratives of experiences, and experiences themselves are beneficial insofar as they give meaning to individuals' crises – a teleological breakthrough after a breakdown. What seems most healing, however, is for the breakthrough to transcend individuals. It is not talking about knowledges gained from crises that is most healing but applying them to heal others. Individuals then become “wounded,” or rather “scarred,” healers.

In Chapter 9, Benyah discusses the conceptions surrounding the causal explanation of mental illness as a prevalent form of chronicity in Ghana. Mental illness is very prevalent in Ghana with an estimated population of about 3 million suffering from different forms of mental illness. However, the conceptions surrounding the causal explanation of mental illness make the approaches adopted in managing or remedying the illness nuanced and more complex. In Ghana and most parts of sub-Saharan Africa, mental illness is shrouded in witchcraft, curses, and supernatural, evil forces. This makes the

sufferers of the illness, family relations, and sometimes health practitioners adopt not only biomedical care but also spiritual resources in remedying the illness. The journey to remedy the cause of a chronic mental health disease can sometimes be daunting and frustrating due to the complex narrative production of diagnostic trial and error in seeking both medical and spiritual resources in the management of the illness. Citing examples from two major prayer camps in Ghana and recounting the experience of individuals who have had a chronic mental health problem, this chapter examines how culture, spirituality, and faith influences the daily experience of people in the management of mental illness and well-being in Ghana.

In Chapter 10, Allen, Ellis, and Hatala explore the increasing prevalence in Belize, Central America, of Type 2 diabetes mellitus (T2DM) as a serious chronic illness and leading cause of preventable death. The purpose of this Grounded Theory study was to better understand how spiritual practices of people living with T2DM affects disease management and mental wellness in Belize. Semi-structured interviews with diabetes patients (n=11), discussions with key informants (n=20), participatory observation, and regular field notes occurred between February and March of 2020. In this chapter they observe that spiritual and religious practices, such as regular prayer, scripture reading, or communal worship, have been shown to improve patient emotional adjustments to T2DM diagnosis, psychological endurance with chronic illness, and improved mental health (including reduced depression and anxiety), glycemic control, and quality of life (QoL). This research suggests that health care providers (HCPs) in Belize can optimize diabetes care through collaboration with patients' spiritual frameworks and faith-based organizations. Similarly, T2DM prevention and education can likely be better facilitated by interdisciplinary efforts that take into consideration faith-based and spiritual perspectives.

Many mental disorders begin during adolescence and young adulthood, with symptoms and distress lasting many years. Chronic suffering and dysfunction are assumed for some diagnoses, such as psychosis, mood disorders and addictions. Chapter 11, prepared by Jarvis, Whitley, and Leblanc, identifies how religious practice and belief (1) challenge the notion of chronicity in mental illness, and (2) mitigate the suffering inherent to severe mental disorder. The literature on chronicity in mental illness is critiqued. Religious case material, derived from 41 patient histories in 2015, and from the Cultural Consultation Service (CCS) and First Episode Psychosis Program (FEPP) in Montreal, Canada is summarized and assessed thematically with respect to chronicity and the distress of mental illness. Findings highlight that religion 1) fosters cultures of recovery that reinterpret mental illness as episodic rather than chronic or degenerative in nature; 2) provides comforting coping strategies that reduce the distress associated with symptoms; and 3) offers meaning and purpose in the face of adversity. Religious variables have been neglected for decades in mental health research despite the consistent finding that religious beliefs and practices are associated with mental health on diverse measures. Religious cultures, beliefs and practices offer powerful tools to assist patients and their families in times of illness and suffering. The re-evaluation of notions of chronicity and wellness, as some belief systems encourage, permit

reinterpretation of illness representations, reduce stigma, and foster recovery. Clinicians need to consider the religious resources that exist in the lives of their patients and plan interventions accordingly. Neglecting to do so may undermine the therapeutic relationship, or unwittingly may worsen suffering over the illness course.

In the concluding chapter, we (Hatala and Roger) highlight major themes that emerged across the diverse chapters in this collection, drawing attention to particular aspects of care and mental wellness, involving both individual and professionalized strategies as well as community approaches. We draw attention to future areas of research we find promising and use as a platform for our discussion concepts introduced by the authors in this collection. The concluding remarks are framed around the promotion of a compelling new concept, based on our discussion around global mental health, namely Global Mental Wellness. This framing of wellness and mental health in a global context is set within the contexts of chronicity and what we refer to as spiritual geographies of care, or the internal and external worlds that provide coping resources, cultural contexts of care, communities of normalcy, and frameworks for interpretation amidst experiences of persistent hardship, crisis, and struggle. This chapter argues that addressing concerning global rates of chronicity and mental illness can, in part, occur by advancing understandings of working relationships across epistemic divides, between biomedically informed health care practitioners and religious or spiritual-based faith practitioners. Overall, it is suggested that when such collaborations are formed through a Global Mental Wellness agenda, the global burden of chronicity and mental illness will be met in a more sustainable manner, appropriately aligned with, and accessing local cultural priorities, community resources, and endogenous solutions that may already be present and active in diverse communities around the globe.

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