Spiritual, Religious, and Faith-Based Practices in Chronicity

An Exploration of Mental Wellness in Global Context

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Chapter 12

Global mental wellness and spiritual geographies of care

Concluding remarks

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12 Global mental wellness and spiritual geographies of care

Concluding remarks

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Introduction

Ten years ago, Manderson and Smith-Morris (2010) changed the landscape of how we understand chronic illness by situating the theory of chronicity in cultural contexts and heightening our sensitivity to the impact of structural factors shaping disease patterns, their management, and outcomes. While much has changed around the world over the last decade, what has remained consistent is the severity of the burden that chronic conditions place on those living with them and the systems of support tasked with their care. On most global indices, the rates of chronic conditions, mental illness, non-communicable diseases (NCDs), and disability have been stable for many years or are on the rise, often advancing across diverse regions, cultures, and pervading socioeconomic classes (Hajat and Stein 2018). Initiated in the 1990s, the Global Burden of Disease (GBD) study represented a scientific collaboration of 500 researchers that quantified the comparative magnitude of health loss due to disease and injury worldwide. Gathering data from across the globe in 1990, 2005, 2010, and 2019, the GBD studies have produced nearly one billion health estimates for 187 countries (GBD 2019; Murray et al. 2013). This research brings into full relief the global health burden of various chronic conditions and mental illnesses, highlighting a global health crisis of chronicity.¹ Similarly, the World Health Organization (WHO) estimated that by 2030, the proportion of total global deaths due to diverse chronic conditions was expected to be 70 percent and the global burden of disease compared to 56 percent in 2010 (WHO 2007). Other researchers have noted that three in five global deaths are now attributed to four chronic conditions, namely, cardiovascular disease, cancer, chronic lung diseases, and diabetes (Wang et al. 2016). Mental and behavioral disorders, in particular, are also now recognized as among the leading causes of chronicity and global disability with an estimated 22.2 percent of all years lived with disability attributable to these disorders, and mood disorders (including major depression, bipolar disorder, and dysthymia), anxiety, alcohol and drug abuse, and schizophrenia among the top twenty (Pike et al. 2013). On other accounts, mental, neurological, and substance-use (MNS) disorders constitute 13 percent of the global burden of disease, surpassing both cardiovascular disease and cancer (Collins, Patel and Joestl 2011). Not without its challenges, the increasing

burden of chronic conditions and mental illness continues to make diverse systems of prevention, management, and care a global priority.

To address these growing health concerns, the fields of public and global mental health deal with illness conditions at the population, state, and global level. The need for a public and global approach to protect and promote health and mental health, as well as to reduce the burden of chronic conditions and mental disorders, is increasingly recognized (Das and Rao 2012; Jakovljevic et al. 2019; Patel and Prince 2010; Wahlbeck 2015). In particular, researchers and practitioners working within the well-known framework of Global Mental Health (GMH) have focused on lessening the burden of mental illness across the world by advancing screening, diagnosis, and care; they are developing, implementing, and evaluating evidence-based practices that can be scaled-up, increasing affordability and access for effective community-based services and interventions, strengthening mental health training of local personnel and laypersons, and promoting, at a more cultural and political level, the value of mental health in societies around the world (Patel et al. 2008; Patel 2014). Today, efforts in GMH often address the growing mental illness inequities between low-income and high-income countries, as well as marginalized or structurally oppressed populations within wealthy nations (e.g., Indigenous peoples, refugees, urban poor) (see Lancet Global Mental Health Group series of articles published between 2007 and 2011; Patel et al. 2008; Prince et al. 2007). Taken together, global health promotion and GMH represent complex endeavors assisting people to protect, improve, and promote their mental health at individual, national, and global levels (Kirmayer and Gold 2012; Patel 2014; Patel et al. 2011).

Despite the efforts to build a solid scientific foundation for global health promotion and GMH, the priorities and frameworks employed to date have been largely informed by mental health professionals and their institutional partners located in wealthy Western countries (Kirmayer and Pedersen 2014). Such approaches tend to reflect the dominant interests of Western knowledge, biomedicine, and psychiatry, and may therefore give insufficient attention to locally defined priorities, worldviews, and cultural perspectives (Mills 2014), including, we would add, an appreciation of spiritual, religious, or faith-based practices and their role in care management. As Kirmayer and Pedersen (2014) observed, there continues to be tension about the application of a public or GMH approach, grounded mainly in biomedicine and current evidence-based psychiatric practices, and transcultural psychiatry that is a more socially and culturally informed community-based approach that emphasizes the social determinants of mental health and the imperatives of listening to local priorities, strengthening community resources, and developing endogenous solutions (Bemmel and D'Souza 2014; Saraceno and Dua 2009; Saraceno et al. 2007). A key concern here, then, is that by addressing global rates of chronic illness and mental disorder through universalizing and Western-centric therapeutic frames that are not necessarily locally relevant and culturally consonant can have potential unintended negative consequences, including inappropriate rates of overdiagnoses and intervention, pharmaceuticalization of mental health and social suffering, displacement of local knowledge and expertise, increased stigma, or poorer health outcomes overall (Dumit 2012; Ecks

2005; Good 1994; Good et al. 2010; Kirmayer and Pedersen 2014; Kleinman 2005; Mills 2014). Indeed, just as GMH tends to emphasize professional mental health interventions exported from biomedically informed positivist or materialistic epistemological frameworks, it also tends to marginalize local grassroots or Indigenous forms of knowledge and care, which include healing, spiritual, or religious worldviews applied for hundreds of years, and accepted forms of social or community integration that can potentially contribute to positive outcomes, wellness, and recovery (Alarcon-Guzman and Castillo-Martell 2020; Hatala, Waldram and Caal 2015; Kirmayer and Swartz 2013; Mills 2014; Sax 2014).²

As this diverse collection of chapters from around the globe attests, a notable portion of the local priorities, community resources, and endogenous solutions to support mental wellness amidst chronicity are found within spiritual, religious, or faith-based strategies. Thus, although global public health and GMH have done much to address current inequities and rising global rates of chronicity and mental disorder on the one hand (Patel 2014; Patel et al. 2011; Patel et al. 2008; Patel and Prince 2010; Wang et al. 2016), and social scientists, cultural psychiatrists, and health researchers have contributed considerably to our understanding of the lived experiences of chronicity and mental illness through interpretive efforts on the other (Good et al. 2010; Manderson and Smith Morris 2010; Mattingly, Gron and Meinert 2011; Sangaramoorthy 2018), important critical questions still remain about how people draw on spiritual, religious, or faith-based resources to manage various chronic conditions, how such spiritual or religious supports help their day-to-day vicissitude, and how such processes also form part of a network of informal care that augments public or institutional services offered through formalized community, biomedical, or psychiatric health care systems.

The chapters in this collection offer a depth of insight into these issues and point to important areas of future work and research. A prominent theme of this collection of chapters is that health and mental health service providers in public institutions or organizations can support, learn from, and utilize a diverse array of spiritual, religious, or faith-based resources that patients prioritize or effectively position in their own daily work of care management. A broad empirical thrust of these chapters, therefore, is to argue that as individual, social, and institutional systems of care, biomedically informed psychiatric and Western trained health care practitioners (psychiatry, psychology, social work, etc.) on the one hand, and religion, spiritual, and faith-based community practitioners (chaplains, healers, etc.) on the other, should be allies in the promotion of mental health and wellness, both for individuals, and also on a broader scale, for a global approach to care. Together, these diverse practitioners have a vital opportunity to jointly shape a future of individual, community, and global care strategies and wellness interventions. By expanding on a global mental health approach on the one hand, and cultural psychiatry on the other, we refer to this framework as *Global Mental Wellness*, a collaborative and interdisciplinary agenda that demands a better understanding of core concepts such as spirituality, religion, and faith, their role in supporting mental wellness amidst chronicity, their potentials for harms and increased forms of distress, as well as an appreciation of their cultural interconnectedness and

respective limits. Moreover, this framework also implies that researchers and practitioners adopt a biopsychosocial-spiritual perspective of wellness in their care that is beyond a typical biomedical vision of health and illness underlying chronic conditions, global health promotion, and mental illness (Hatala 2013; Manderscheid et al. 2010), and at the same time, legitimize the inclusion of a spiritual domain in epidemiologic discourse on the global determinants of chronicity, mental health, wellness, and healing (Jakovljevic et al. 2019; Levin 2003).

In this concluding chapter, we highlight major themes that emerged across the diverse chapters, drawing attention to particular aspects of care and mental wellness involving both individual strategies and community approaches. We also draw attention to future questions and areas of research the authors point to that we find promising. By and large, the authors in this collection do not reproduce narratives of globalization and change documented over the years. Nor is their intent to dwell on images of suffering, passivity, and stigma that can be prevalent in discourses of chronicity, social suffering, precarity, or global illness, especially those concerning individuals and communities suffering from mental illness in impoverished nations (Desjarlias et al. 1995). Rather, the goal was to explore—through over 300 in-depth interviews analyzed in the different chapters with individuals living in chronicity and those offering care, as well as extensive ethnographic observations from nine diverse global contexts including, Brazil, Belize, Canada, France, Ghana, Germany, Netherlands, Somaliland, United Kingdom—how various religious, spiritual, and faith-based practices and worldviews can augment mental wellness amidst chronicity. This is not to ignore or excuse the ways in which religion and spirituality can and have had negative impacts on individuals and communities. Knowing and respecting this reality, however, this collection and these authors focus on a positive or strengths-based approach, providing different forms of evidence about how religious, spiritual, and faith-based practices and worldviews support peoples' daily living. In so doing, we frame our concluding remarks around the promotion of Global Mental Wellness within the contexts of chronicity and what we develop as the spiritual geographies of care. We conclude that by building greater understandings of and working relationships across epistemic divides of biomedically informed health care providers and religious, spiritual, or faith-based practitioners—and ultimately between science and spirituality more generally—the potentials for individual and public harms and distress related to religious or spiritual practices and worldviews can be mitigated and the global burden of chronicity and mental illness can be met in a more sustainable manner, appropriately aligned with and accessing local priorities, community resources, and endogenous solutions that may already be present and active in various communities around the globe.

Mental wellness and the spiritual determinants of chronicity

The word “chronicity” stems from Latin “chronicus” relating to time and from the Greek “khronikos” or “khronos,” meaning of time. It designates the “condition of being chronic,” and typically refers to an illness condition that is

“prolonged or slow to heal” or social suffering and distress that “continues over an extended period of time” (Sangaramoorthy 2018; Vigh 2008). Sue Estroff (1993, 250), in her life course research with schizophrenia patients, defined chronicity as “the persistence in time of limitations and suffering and to the resulting disabilities as they are socially and culturally defined and lived.” In so doing, Estroff argued that conditions of time, development, social relations, and broader contextual or cultural factors driving health care structures and supports together give rise to or inhibit meaning-making processes during lived experiences of chronicity.

In positioning chronic illness and social distress in the context of globalization and global health, social scientists have since argued the need to interrogate how perspectives of chronicity are often reflective of the particular cultural and historical traditions of Western biomedicine, and the interpersonal and structural power relations within its many global manifestations (Good 1995; Manderson and Smith-Morris 2010). As part of this critique, critical health researchers have underscored how essential it is to problematize “chronicity” as a construct, highlighting the need to relate chronic health issues to social inequity and injustice (Lock 2001; Manderson and Smith-Morris 2010; Miles 2010). “Chronic” here is typically viewed as the persistence of symptoms over the course of a disease or social struggle for which there is no immediate remediation. Medical anthropologists have since challenged such biomedically informed discourses of chronicity, calling for a shift from conceptions of illness as temporally bound toward an understanding of the fluidity and flexibility of illness and social conditions over the life course (Manderson and Smith-Morris 2010; Sangaramoorthy 2018). Researchers have also highlighted the various processes of disruption, transition, and transformation that constitute chronic experiences (e.g., HIV, poverty, war, psychosis, diabetes, and even global pandemics) and how continuous day-to-day management poses significant medical, economic, and psycho-social challenges, and especially for those in resource-limited settings (Farmer 2004; Lund et al. 2010; McGrath et al. 2014; Russell and Seeley 2010; Watkins-Hayes, Pittman-Gay and Beaman 2012; Vigh 2008). In medical contexts, researchers have also troubled long-standing dichotomous relations between “chronic” and “acute” by exploring how a variety of everyday life conditions (e.g., sleep, trauma, birth, aging, and addiction) and forms of social suffering are increasingly medicalized, highlighting the many domains of life that are gradually viewed through a “chronic” lens and thereby requiring constant medical or pharmaceutical intervention (Dumit 2012; Goodman et al. 2013; Manderson and Smith-Morris 2010; van der Lee et al. 2007). These critiques emphasize the various frameworks through which chronicity can be viewed and the difficulties or potential dangers of universally applying, and also prioritizing, biomedically informed, Western-centric categories and therapeutic frames given the many ways that societies and cultures shape persistent experiences of distress and illness, as well as the ways in which people seek relief, wellness, and care (Ecks 2005; Fassin 2012; Good et al. 2010; Miles 2010).

What emerged across the chapters in this collection was that through spiritual, religious, and faith-based worldviews and practices, chronic conditions of various

kinds—whether intermittent psychosis, oppressive forces of colonization and social marginalization, attacks of spirit possession, or other forms of persistent mental duress—were often externalized from individual-level suffering, symptoms, or diagnostic categories (Jarvis et al. Ch. 11; Moratz Ch. 4; Morton et al. Ch. 7). This externalizing is, in part, what fostered the construction of meaning, purpose, and “recovery” despite enduring forms of social and individual suffering. Chronic illness in this context is reimagined as outside the person, not as part of the core spiritual self (McGregor and McKinley Ch. 3). It, the illness or unjust social affliction, can then be changed, transformed, or engaged, while the core self is unharmed. Although such forms of chronicity can emerge from a spiritual worldview and conception of reality (e.g., spirit possession), the individual sufferer was not always bound by an “illness identity” of some kind and concomitant stigma that may occur in a more individualized or secularized context (Becker 1998; Charmaz 1991; Estroff 1993; Hatala, Waldram and Crossley 2013).

Moving one step further, while some chapters detailed the self, illness, or personalized social distress, some focused more on the value of relationships in the context of spiritual communities. Indeed, a specific theme that emerged from the chapters was how chronicity was oftentimes negotiated within relational contexts and was indeed a relational process. In other words, if the context or processes surrounding the chronicity are transformed or given a new meaning, then often this in itself was an important factor ameliorating its potential harms. In this way, spiritual, religious, and faith-based practices fostered “cultures of recovery” that, as they reinterpreted chronicity as temporary intrusions to a stable core self, emphasized wellness as a deeply personal journey involving growth and transformation, flexibility and adaptation to particular contexts and circumstances (Jarvis et al. Ch. 11). This recovery “journey” also involved movements across and within what we refer to as spiritual geographies toward wellness and a more positive view of the future (Remy-Fischler Ch. 8). Healing, recovery, and transformation amidst chronicity, then, was as much about a spiritual worldview as it was about a relationship between aspects of the self, and others, and the self with the external world—a person in context moving forward in helpful or healing-oriented relationships, and especially those of a spiritual nature. Thus, the chapters in this collection push us to consider more deeply what could be called the *spiritual determinants of chronicity*; that is, the various forces that impact the psychological, phenomenological, and moral experiences of time and struggle, and how specific spiritual, religious, or faith-based practices help to shape and reshape those experiences in wellness affirming ways. Whether through nourishing exchanges during Catholic pilgrimage to Lourdes’ holy shrines in France (Goldingay et al. Ch. 6), the aesthetics of care in Brazilian spiritual surgeries (Kurz Ch. 5), sacred prayer and dance of honoring the ancestors by Garifuna Indigenous families in Belize (Allen et al. Ch. 10), or becoming good ancestors through subtle forms of ceremony-making among urban Indigenous youth in Canada (Morton et al. Ch. 7), these practices shifted contexts of relationships towards a hoped-for future, thereby transforming a challenging past or present into an imagined landscape of possibility.

Along these lines, the chapters in this collection also exemplify how the nature of chronicity can vary based on the creation and recreation of complex networks or communities of care. While there is evidence that people with chronic conditions and mental illness can face stigmatization and social exclusion in various ways (Mehta and Thornicroft 2013), there is also some indication that people whose behavior is not threatening or disruptive may be better integrated in smaller communities and cultural contexts where unusual experiences are not necessarily labeled as shameful and discriminated against, but may be given positive meaning and moral value (Goldingay et al. Ch. 6; Benyah Ch. 9). Moreover, as research has shown, the course and outcome of various chronic conditions, and especially forms of severe mental disorders, may depend not solely on access to services, medication, skills, and the availability of professional care, but also on the reactions to individual persons in a holistic way, to the tone and manner of care provided, and to the support provided by family members and the immediate social network of community resources (Adeponle, Whitley, and Kirmayer 2012; Campbell and Burgess 2012; Good et al. 2010; Myers 2010). As such, there is growing evidence that connected communities with programs designed to promote social inclusion, spiritual networks, and empathy have the potential to make an important contribution to mental wellness (Alarcon-Guzman and Castillo-Martell 2020; Jakovljevic et al. 2019). Indeed, as the chapters in this collection describe, connections with communities fostered by spiritual worldviews and ethos, in particular, disrupted and re-interpreted experiences of isolation, sequestration, stigmatization, or how the ill or precariously suffering are often set apart spatially from mainstream populations. What these chapters outline is how spiritual, religious, and faith-based practices can embrace and draw people together under a common empathic framework or vision of sacred reality, and this context and form of relationality fundamentally changes the experience and process of chronicity. A key component of a Global Mental Wellness agenda, therefore, must also include inquiry about how communities grounded within and inclusive of spiritual aspects of reality can challenge the stigmatization or social exclusion so often afflicting those with mental illness and other forms of chronicity globally, and how such spiritual networks of care can shift our common perceptions of chronicity and stigma in both form and process.

Spiritual geographies of care

For many individuals around the world, living amidst chronicity and the pursuit of mental wellness extends beyond a local material and social world of existence. The daily concerns of chronicity often include movement across and within the *spiritual geographies of care*, the internal and external worlds that provide coping resources, cultural contexts of care, communities engendering a sense of belonging and purpose, and moral frameworks for interpretation during experiences of persistent hardship, crisis, and struggle. This idea of geography is appealing in part because it can be used both literally and metaphorically; it can refer to a kind of figurative internal psychological or existential terrain as well as to the physical

features of land, community, and sacred places on the earth. Indeed, as the different chapters outline, the transformation of and movement across spiritual geographies is at once psychological, with respect to an inner journey of self-interpretation or meaning-making amidst challenging experiences that find direction and guidance from spiritual insights, connections, and realities; phenomenological or embodied, insofar as the mode of dwelling in and inhabiting a world is transformed or reimagined by conducting spiritual activities, engaging with sacred communities, and benefitting from those relationships; and moral insofar as such activities resist and challenge dominant normalizing discourses of identity often-times carried within a global health agenda and its universalizing Western-centric therapeutic frames, and thereby invite innovative alternatives for wellness amidst social suffering and chronicity. In this way, the idea of geography is also appealing because it signifies spaces and places of resistance to universalizing expansions of medicalization in general, and a pharmaceuticalization of mental health and social suffering in particular; it remains a site of challenge to encroaching secular biomedical worldviews and notions of moral normalization. These spiritual geographies of care, insofar as they exist at all, resist, in various ways, the globalizing powers of a Western-centric rationality that can, at times, ethically impel action on populations and subjectivities overtly, as well as ideologies, epistemologies, and ontologies perhaps more covertly (Good 1994). It is here that “global health is also about competing truths and competing ethics” (Fassin 2012, 107).

Within these contested geographies, the chapters in this collection also allude to a spiritual or religious modernity (Moratz Ch. 4), that is, the bringing of a contemporary capacity for spiritual engagement with a physical habitation in particular spaces and places, times across history and into the present. Spiritual geographies therefore also encompass external notions of land and nature in that they can respond to colonial histories of stolen land and at the same time inform transformative healing from cultivating sacred relationships with or repossession of the land (McGregor and McKinley Ch. 3; Morton et al. Ch. 7). Similarly, they are reflective of deepening reconnections with a sense of being “grounded” on the soil as part of a pilgrimage where one is moving towards or within a symbolic place like Lourdes, France (Goldingay et al. Ch. 6), or accessing the peaceful and calming environments surrounding prayer camps in Ghana, Western Africa (Benyah Ch. 9). From these external geographies, and how they shape and inform the experiences of care, wellness, and chronicity, spirituality is not simply the individualized practices performed in the day-to-day phenomenal world; it is also fundamentally about an embodied world, a place and space, practices which require physical manifestation and holding ground, and a worldview where supernatural and other-than-human interactions and relationships are a normal and expected aspect of existence.

Appreciating spiritual geographies of care demands a deeper understanding of spirituality, how it relates to related concepts of religion and faith (Freitas et al. Ch. 2), and how it cultivates determinants of chronicity and wellness, those both potentially supportive and harmful. As the chapters in this collection outline, spirituality can be understood as a quality of human beings who are

concerned or preoccupied with higher meaning or purpose in life rather than solely with affairs of the material world (Jarvis et al. Ch. 11; Benyah Ch. 9). In this way, spirituality is a dimension of human experience related to the sacred or a transcendent reality widely defined. Spirituality also relates to the inner essence of the self or human nature, and the sense of harmonious inter-connectedness with self, others, the world, nature, and the spiritual aspects of reality (Freitas et al. Ch. 2; McGregor and McKinley Ch. 3). At the individual level, transformation, vitality, meaningfulness, and connectedness each are essential elements of a spiritual experience (Remy-Fischler Ch. 8). Indeed, a form of connectedness or belonging emerged as a core aspect of spirituality outlined by many of the chapters, seen as a feeling of union or harmony with another being or place, engaging in meaningful practices that center or align the outside and the internal worlds, and for some, this includes relationships with a living prophet, dead or imagined persons, a cultural, ethnic, or political group, nature and land, or the universe (Allen et al. Ch. 10; Kurz Ch. 5; Morton et al. Ch. 7). Despite differences in perspective or terminology, the chapters reflect similar spiritual perspectives in current literature (Canda and Furman 2009; Fisher 2011; Ho and Ho 2007; Hungelmann et al. 1996), especially the capacity to be conscious of oneself, to achieve peacefulness and growth despite illness-induced limitations, and to have a relationship with other-than-human persons that can support and relate to humans in diverse ways (Jarvis et al. Ch. 11). Thus, we found the term spiritual geographies of care useful insofar as it helps us consider both the internal and external “places” where practices that promote connections, transcendence, meaning-making processes occur, and especially the vicissitudes or movements across different spaces of meaning, growth, flexibility, recovery, and trust. Whether in a remote Pentecostal prayer camp in Ghana (Benyah Ch. 9), during spiritual support groups in the United Kingdom (Remy-Fischler Ch. 8), Qur’anic healing from spirit possession in Somaliland’s *cilaaj* clinics (Moratz Ch. 4), or in one’s rural Belizean home during private moments of fasting and prayer (Allen et al. Ch. 10), care and wellness are felt and known in diverse ways by traversing these spiritual geographies.

Connected with spirituality, religion is arguably one of the most distinctive human phenomena that has been and continues to be a source of individual and community growth, strength, social solidarity, and resilience, as well as a source of personal strain, terrorism, and interreligious conflict (Abu-Raiya 2013; Csordas 2009). As the chapters in this collection highlight, religion can depict a particular institutionalized or personal system of beliefs and practices (worship) related to the divine (Moratz Ch. 4), as well as provide particular patterns of practice for people to follow and draw strength from (Jarvis et al. Ch. 11). These practices concern the existence, nature, and worship of God or spirits, and divine involvement in the universe and human life, as well as concerns with the next world or a life after death (Kurz Ch. 5). Religious pathways can be complex and dynamic processes in which people are in search of whatever they hold significant, including faith, family, community, or the sacred itself (Freitas et al. Ch. 2). As other chapters also explore, religious figures and

educators can provide great stories or prescriptive meta-narratives about how people should and could live in the context of prolonged suffering (Allen et al. Ch. 10; Remy-Fischler Ch. 8).³

As an aspect of both religious traditions and spirituality, faith was another common theme in the chapters, outlined as confidence or trust in relationships with others, with certain practices, and a spiritual realm of other-than-human persons (Allen et al. Ch. 10). Faith-based practices, then, can involve those activities motivated by such convictions and conscious knowledge of one's spiritual nature and reality. Faith can also be healing by connecting individuals to like-minded groups that can offer tangible and emotional support and encouragement (Remy-Fischler Ch. 8). Faith can also support wellness by engendering soothing emotions that buffer or mitigate the harmful effects of stress (Kurz Ch. 5). In this way, faith can support wellness outcomes by establishing an interpretive framework, a mode of thinking and explanatory narrative that affirms one's innate sense-making ability, better accommodating individuals to their challenging life experiences and place in the world (Morton et al. Ch. 7). Research also now suggests that such feelings and interpretations elicited by positive faith-based thoughts, beliefs, and experiences, personal or communal, may promote neurobiological resilience by directly modulating various neurological and epigenetic parameters indicative of pathophysiology (Russo et al. 2012).

Similarly, hope is also a familiar and important topic in anthropological discussions of chronicity and wellness (Mattingly, Gron and Meinert 2011). Although previous research has explored the way that living with chronic conditions can create significant life disruptions and even despair (Becker 1997), the chapters here also highlight the ways in which hope is a process harnessed and opened by spiritual and religious connections, communities, and relationships (Allen et al. Ch. 10). Important, too, is that hope is fundamentally about the future, about projecting one's faith into a future time where struggle and hardship may be mitigated, or where one's actions are seen in the context of future generations and sacred relatives or ancestors (Morton et al. Ch. 7). As people produce future hoped-for scenarios of action by anticipating and predicting the near and distant future through a social and spiritual imaginary, they locate themselves in the world in relation to other actors, both material and spiritual, and seek to grasp a sphere of existence previously unexperienced yet nonetheless moved towards in anticipation. Action and environment here are in constant dialogue (Vigh 2008), yet the self is not just in relation to context or environment of a social or material making, but a spiritual realm with other-than-human persons in deep relationship with and witnesses to human suffering and striving (McGregor and McKinley Ch. 3). In this way, one of the key roles of spirituality, religious, and faith-based striving in chronicity is about carving out futures, centered on notions of hope and wellness, that people reach for and inhabit in various ways.

The fact that those drawing on religious, spiritual, or faith-based forms of support and care have been frequently associated with higher degrees of wellness and quality of life, optimism, and happiness when compared to people who do not draw on such resources is widely supported in current scientific literature (de

Bernardin et al. 2017; Roger and Hatala 2017; Peres et al. 2018). Likewise, religiousness and spirituality can also help people deal with stressful situations and emotions, like fear, anguish, sadness, and anger, because they tend to develop internal cognitive mechanisms that help people reframe experienced adversities in new ways (Hatala, Desjardins and Bombay 2016; Pargament, Feuille and Burdzy 2011). As spirituality and religiousness are components of people's psychological wellness, there is even evidence showing an association between low levels of spiritual and religious beliefs or practices with increased mental illness or impairment (Weber, Lomax and Pargament 2017) and greater risk-taking behaviors (Hatala et al. 2020). Since 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), it is important, in both the private and public sectors, to identify how to better utilize these evidence-based resources, and how doing so involves an expanded notion of wellness and "recovery" amidst chronicity (Jarvis et al. Ch. 11). In this context, the idea that people living with chronic conditions can experience wellness, and furthermore, that spirituality and faith-based practices may be supports towards wellness, may problematize and challenge the increasing medicalization of a so-called "popular health sector" of home-based care (Mattingly, Gron and Meinert 2011).

Although this collection and these authors focus on a strengths-based approach, it is furthermore important to highlight that the chapters in this collection do outline various moments when religion and spirituality can become a source of conflict and tension (Jarvis et al. Ch. 11), or when relationships with other-than-human persons are a cause for worry and struggle (Moratz Ch. 4). It is crucial to appreciate, therefore, that the practice of religion and spirituality can harness deeply negative aspects of oppression, harms, and abuses, underlining intolerance and stigma rather than the positives ideals such as compassion, justice, and love (see Morton et al. Ch. 7 for examples in the contexts of settler colonialism). As such, at the individual level these potential negative impacts for some need to be acknowledged by care providers and practitioners. Working with individuals may require that practitioners have knowledge of historic harms, systemic abuses, or well-known infractions caused within religious groups, or by specific spiritual practices, so that they can better support individuals on their wellness journeys. Religious, spiritual, and faith-based worldviews and practices, in this sense, may indicate their own contexts of struggle, challenge, and additional duress, and should therefore also be explored as part of the spiritual determinants of chronicity. More broadly at global levels, one must also recognize that these potential harms and variations of experience are partly shaped by geopolitical, cultural, and macro psychosocial contexts (Zimmer et al. 2018). Accordingly, another key element of a Global Mental Wellness agenda and important area of future research involves a better understanding of how spiritual geographies of care can be both a source of hope and strength, dealing with mental wellness but also working through harms possibly produced by religious or spiritual affiliations, as well as a source of tension or added stress when those harms appear to be unresolvable, and especially how these dynamics might compound or impact other modes of care and help-seeking and vary based on place and space.

Towards a collaborative Global Mental Wellness agenda

The chapters in this collection indicate that, despite notable tensions and potential harms, diverse contemporary forms of global spiritual and religious consciousness continue to permeate humankind. According to a comprehensive demographic study of more than 230 countries and territories conducted by the Pew Research Center's Forum on Religion and Public Life (2020), it is estimated that in 2020 there were 6.6 billion religiously affiliated adults and children around the globe, representing 84 percent of the world population of 7.8 billion.⁴ These numbers are expected to grow in future years. Notwithstanding an outmoded secularization theory that assumed religious or spiritual worldviews and practices would gradually disappear and be replaced by a scientific rationality in a modern world (Habermas 2008), religious and spiritual worldviews and practices have maintained, reformulated, and re-envisioned relations between the sacred and mundane, spirit and matter, within everyday individual and social life. As Csordas (2009, 91) similarly notes in relation to what he called "global geographies of the spirit" in Catholic Charismatic Renewal, "contrary impulses toward universal culture and cultural fragmentation have both become imbued with an aura of enchantment" and that:

At the least, such phenomena are of interest because they constitute the religious dimension of a global social system; at the most they portend that religious consciousness will be seen to be a defining feature of contemporary global consciousness.

If religious, spiritual, and faith-based practices remain a significant force in the lives of many people on the planet, then humanity—and particularly the scientifically informed biomedical community endeavoring to alleviate the health burdens of a global crisis in chronicity—must in some way come to terms with the roles and spaces such practices occupy in the modern world.

We thus conclude that the future solutions to the rising health problems of chronicity and a global burden of mental health disability will involve, to some extent, a Global Mental Wellness agenda that is grounded within a contemporary "religious consciousness" (Csordas 2009) or "post-secular modernity" (Habermas 2008). This vision embraces the spiritual nature of humanity, our interactions with aspects of spiritual reality, and values the knowledge, connections, and relationships that emerge from these worldviews as important resources for care and mental wellness. At its core, this agenda will involve learning about strengthening relationships between spiritual, religious, and faith-based care providers on the one hand, and biomedically informed health care practitioners variously defined on the other—a practical harmony between science and spirituality. The one can and should not ignore the other, given that both, in different ways and spheres of influence, endeavor to improve chronic and poor mental health in various ways. If this collection does anything useful, we hope it can help stimulate and advance a necessary conversation amongst stakeholders across the mental health and

wellness expertise divide to take steps towards collaboration between the silos of care. As most of the chapters in this collection illustrate, both have much to offer each other. To mitigate the growing burden of global mental illness and chronicity, therefore, we argue it is time to take a more nuanced look at the ongoing role of religion and spirituality in the modern world and to explore their potentially constructive contribution to global health and wellness. These are not arguments in favor of one existing religious or spiritual system over another. On the contrary, it is a position where we move beyond sectarianism or cultural fragmentation in our understanding of such worldviews and practices. The health sciences and religion or spirituality should (and can) have the same goal of promoting individual, public and global mental wellness for those who practice in a faith-based way, predicated on a positive and optimistic view of human nature, deepened awareness of body-mind-spirit interactions and relationships, and a spiritual domain and worldview (Jakovljevic et al. 2019; Levin 2003).

Moving towards a practical science-spirituality harmony as envisioned here is no easy task, yet it is essential if meaningful intersectoral collaborations across epistemic domains are to be advanced in respectful ways. At one level, this will involve a certain reformulation of terms and concepts. In a pragmatic and simplified way, both science and religion or spirituality, at their best, can be viewed as complementary systems of knowledge and practice concerned with the betterment of humanity (Arbab 2018). Science here is largely concerned with an exploration and application of material truths, whereas religion or spirituality are largely concerned with the exploration and application of non-material (or spiritual) truths. Importantly, then, science and religion or spirituality conceived in this way significantly overlap: both are largely concerned with service towards and the betterment of the human condition; both can involve the exercise of rational thought, imagination, and intuition, as well as skeptical thinking; both rely on disciplined and systematic observations in the pursuit of knowledge and its generation; and both require virtues, such as curiosity, honesty, integrity, and cooperation. As well, we see parallels in that both share a recognition of the fallibility of human knowledge, which invites humility and openness; both are, to a great extent, social enterprises pursued by communities of people that need to develop shared vocabularies and complex forms of social interaction and organization; and both must contend with a variety of individual, social, and political forces that can distort or pervert their expression (Arbab 2018; Smith 2019). For these reasons, it is important to avoid false dichotomies between science and religion or spirituality; rather, it may be fruitful for the kind of collaboration we envision that they are understood as evolving, complementary, and overlapping systems of knowledge and practice that require ongoing efforts and “normative discourses” to ensure their practices and tangible applications are aligned with ideal principals (Karlberg 2020).

This notion of “normative discourses” that regulate practice and application requires deeper consideration when approaching a sought-after harmony between science and spirituality. While such discourses can bring about a useful standardization for practice and ensure ideal principles are adhered to, they can also lead to harmful stigmatization and oppression of large groups of people and knowledge

systems. In the history of science, universalizing normative discourses began with rational and empirical standards and have since expanded to include ethical standards of practice along with institutional mechanisms needed to enforce them and train future scientists under their ideals (Oreskes 2019). The gross ethical failures of previous scientific research—such as the infamous Tuskegee study or eugenics programs to take but two examples—propelled the widespread establishment of standard institutional ethical review boards and peer review processes for the protection of human rights and personal safety (Oreskes 2019). Although such practices are considered normative today, these ethical failures of the past indicate that normative standards evolve over time as communities of practitioners engage together in discourse and practice about the scientific enterprise as a whole (Arbab 2018). While such training, sociocultural processes, and standards are far from perfect and ethical violations can still occur, some form of public accountability and acceptability is increasingly regarded as essential to the “proper” practices of science today (Karlberg 2020).

Perhaps, then, we can also consider how diverse religious, spiritual, or faith-based practices could be subject to parallel forms of public accountability and acceptability, both locally and globally. This kind of heightened public discourse could be an important step to ensure that the harmful abuses and human rights violations that have occurred in the name of religion or spirituality are seen as distinct from an envisioned science-spirituality harmony. Indeed, as Karlberg (2020, 73) has observed regarding the role of religion in modern society:

Transcending conflict and violence committed in the name of religion has become a global imperative. Even though this will not be easy, the stakes have become too high to ignore this. But this will require a deep rethinking of the concept of religion and its normative dimensions, along with a corresponding change in the way we invoke the term “religion.”

Thus, just as scientific practice has clearly become an object of growing public scrutiny in recent years, and critical assessments of practice are regular themes in contemporary public discourse (Oreskes 2019), so too, we argue, could religious and spiritual practices that aim to support the wellness of diverse groups of people around the world also be held to a parallel set of common principles, those based on, for example, a peaceful coexistence or the promotion of wellness or social justice (Karlberg 2020). The advancement of discourses about accountability and acceptability of spiritual, religious, or faith-based practices—in ways that would adhere to local priorities and knowledge while also seeking broader common principles and connections—would likely help to refine and define what is meant by these core terms in relation to chronicity and wellness, delimit terrorism, violence, oppression, and other forms of abuse as valid forms of religious or spiritual practice, and clarify for skeptical health practitioners and global human rights advocates what is meant by the sought after science-spirituality harmony underlying a Global Mental Wellness framework.

The chapters in this collection highlight that much work is needed if we are to take seriously and advance these aims, at the individual, community, and more structural or global levels. In a review of the relationship between schizophrenia and religion, for example, Mohr and Huguelet (2004) reported that patients' concerns about their psychiatrists' views of their spiritual or religious beliefs kept them from discussing religion or spirituality with their psychiatrists. Similar findings were also reported by Ho et al. (2016) and Osokpo and Riegel (2019). This tension is not an uncommon story, especially in global contexts of Indigenous health and healing (Allen et al. 2020). Largely related to observed dichotomies between or tensions among spiritual, religious, and scientific domains, this situation reveals that there can be a lack of discussion, understanding, and consensus between patients and various health or mental health professionals regarding spirituality and religious matters, a theme also stressed by the authors of this collection from multiple perspectives.⁵

By accepting that there is a vital spiritual component to personhood, at least in the worldview of many individuals, health practitioners may be better equipped to mobilize the salutogenic spiritual resources that can, in many ways, facilitate wellness alongside, or in addition to, a biomedically informed approach to care. At the individual level, therefore, clinical history-taking ought to include an assessment of a patient's religious and spiritual history and current cultural practices (Allen et al. Ch. 10; Jarvis et al. Ch. 11). Inventories and assessment tools exist in growing number for use by primary care physicians, psychiatrists, and mental health providers, with healthy patients and both medically and psychiatrically ill patients, and for assessment of normative practices and beliefs and experiences, religious, or spiritual problems, and a history of spiritual interventions, such as faith healing (Levin 2003). Biomedically informed mental health professionals can also make timely referrals, where appropriate, to professionals trained in pastoral counseling or psychology, as well as Indigenous or spiritual healers variously defined, and examples of these informal or formal partnerships in Canada and elsewhere seem promising (Allen et al. 2020). Pursuit of these partnerships can ensure that growing concerns for and acceptance of cultural sensitivity and safety in clinical encounters and patient care is expanded to include spiritually sensitive and safe care as well (Jarvis et al. Ch. 11). Although some steps have advanced in recent years towards appreciating the religious and spiritual forces shaping individual lives and wellness outcomes (Büssing and Koenig, 2010; Habermas 2008), there is still much work to do in building trust and respect required for integration across epistemic worldviews, cultures of healing, and diverse systems of care.

From another vantage point, with an estimated shortfall of over one million mental health specialists in Low Middle Income Countries (LMICs) (Kakuma et al. 2011), there is also a need to look for local resources, models of community integration, and partnerships across diverse sectors of expertise to bridge a growing global care gap for chronic conditions and mental illness. Consequently, it is essential that global health practitioners learn to increase the number and variety of skilled workers prepared to address diverse health care needs, and that this increased human capacity be deployed in integrated

community-care settings, especially beyond the stand-alone mental health hospital (Kakuma et al. 2011). Multiple demonstrations validate these kinds of innovative collaborative strategies, involving task-sharing as both cost-effective and feasible (Patel et al 2007; Patel 2014). The WHO Mental Health Gap Action Programme, for instance, has articulated a prioritized set of conditions and promotes capacity building by enhancing the training of non-specialized care providers in integrated community settings (Patel et al. 2007). As part of their grand challenges in global mental health, Collins, Patel and Joestl (2011) similarly argued for advances in areas around community wellness and collaboration: 1) to support community environments that promote physical and mental well-being throughout life; 2) to provide effective and affordable community-based care and rehabilitation; and 3) to develop sustainable models to train and increase the number of culturally and ethnically diverse lay and specialist providers to deliver a variety of care services. Research also underscores that the need to scale up health care resources within countries cannot be a singular strategy, nor may it be the most effective alone (Alvarado et al. 2013; Kakuma et al. 2011).

As this collection suggests, such appeals for community integration and intersectoral partnerships must involve a more serious consideration of the resources that spiritual, religious, or faith-based practitioners and communities can offer. Part of this needs to be an acknowledgement that biomedical or mental health practitioners are not the only ones with experience, expertise, and capacity to care for people with mental illness and various kinds of chronicity. Part of this, too, needs to be an appreciation of the knowledge, capacity, and evidence-based endogenous solutions such diverse spiritual or faith-based practitioners can hold and utilize in their own ways (Allen et al. 2020). Whether Indigenous Elders working to build and restore connections to the land and a spiritual identity (McGregor and McKinley Ch. 3), spiritual chaplains serving as counselors in a hospital or hospice setting (Freitas et al. Ch. 2), Spiritual Peer-Support Networks that support meaning-making transformations within diverse contexts of mental health care (Remy-Fischler Ch. 8), or spiritual healers of various kinds supporting patients in rural areas as well as urban centers (Benyah Ch. 9; Kurz Ch. 5), such practitioners and the communities they represent signify, we argue, an important hidden resource that can help address the global care gaps for mental illness and chronicity, and thereby increase global opportunities for enhanced wellness across multiple domains. Indeed, as others have also noted, finding “windows of compatibility” to enhance collaboration between formal mental health services and traditional Indigenous healers, for example, may offer a complementary pathway toward more locally accessible resources for community-based care (Hatala 2008; Hatala and Waldram 2016; Ndeti et al. 2008; Waldram and Hatala 2015). A Global Mental Wellness framework, therefore, must consider alternative models and innovative social or community strategies of care beyond those typically informed primarily by a biomedical, Western-centric framework in order to close a growing global care gap in these areas.

As Kleinman and Hall-Clifford (2010, 251) also observed, “chronicity makes it unavoidable that professional and family caregivers move to the center of our understanding of health care” and that “this will require a cultural revolution in global health planning and program development.” We agree with these authors that in the global context of chronicity a “new agenda for global health” is required, one that “reimagines the role of health services and the role of communities of care” (251). Yet, we contend that this “new agenda” must move beyond the social and material conditions of biomedical care, Western knowledge systems and expertise, questions of access and distribution, or public health interventions. Rather, these conversations around a “new agenda” must begin to push into and embrace the spiritual, religious, and faith-based resources that people access and traverse alongside family caregivers and various community professionals to provide care and support their mental wellness outcomes amidst chronicity. Moreover, even the shift in recognizing the “largely unexplored” realm of the “popular health sector” mentioned by Mattingly, Gron, and Meinert (2011)—where treatment and care of sickness take place in families, among friends and neighbors in homes and communities—does not adequately acknowledge the spiritual geographies traversed during the day-to-day management of chronicity. Thus, although rightly critical of globalization and modernity, universalizing and Western-centric therapeutic frames, capital flows and enterprise, medicalization, pharmaceuticalization of mental health and social suffering, bio-power and expert control of the body and health care (Dumit 2012; Ecks 2005; Good 1994; Good 1995; Inhorn and Wentzell 2012; Manderson and Smith-Morris 2010; Mills 2014; Susser 2009), medical anthropologists and critical social scientists have done little to interrogate the spiritual determinants of chronicity, that is, the vital relationships with spirits, ceremony, other-than-human persons, the nexus of care within sacred communities, spiritual connections with the land and a sacred identity, prayer, fasting and diverse spiritual practices, among other aspects, that various individuals draw on to augment care and mental wellness. Thus, the “new agenda” that Kleinman and Hall-Clifford (2010) called for us to consider could build on the Global Mental Wellness framework traced out here, and indeed we hope this diverse collection of chapters can serve as an initial theoretical and empirical point of departure for others to pursue.

In conclusion, based on the chapters and recommendations outlined in this collection, we envision certain structural arrangements regarding collaborative systems of care that are: 1) *based* on a model of wellness and recovery that involves a mind-body-spirit balance across diverse cultural contexts of care; 2) *designed* through engagement with affected individuals, their families, and their communities, as well as with the relevant faith-based, religious, or spiritual care practitioners; 3) *governed* in a culturally appropriate, sensitive, and safe way integrating local traditions, healers, knowledge keepers, and through the customs of people by which they are offered; 4) *offered* by collaborative teams of medical professionals, faith-based healers, or spiritual and religious communities of care seeking to balance evidence-based practice with a science-spirituality harmony; and 5) *accessible* to all people and their families founded on

models of spiritually informed community-based care. Taken together, this collection offers a critical discussion of and outlines some strategies for future research, intervention, and clinical practice, based on a “post-secular” worldview that is multisectoral, cross-cultural, transdisciplinary, and balanced across insights from science and spirituality (Habermas 2008). This will, we hope, in part provide the basis for a Global Mental Wellness agenda that is more inclusive, participatory, and responsive to local spiritual, religious, and faith-based practices, worldviews, strengths, resources, and realities that have great potential to enhance mental wellness and care for those struggling with various forms of chronicity around the globe.

Notes

- 1 The Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) 2019 provides a rules-based synthesis of the available evidence on levels and trends in health outcomes, a diverse set of risk factors, and health system responses. GBD 2019 covered 204 countries and territories, as well as first administrative-level disaggregations for 22 countries, from 1990 to 2019.
- 2 There are also the additional critical reflections Fassin (2012) offers regarding a global health agenda, particularly that the notions of both “global” and “health” are not so clearly defined or understood. As Fassin argued, “the globalization of health must therefore be thought of as a heterogeneous and contested historical phenomena...” (p. 99) and that “this unique combination of expansion and normalization, of failures and resistances, of abandonments and rumors, suggest that globalization is definitely not the monolithic homogenizing process many have denounced, but rather a melange of uniformity and distinctions, of power and innovations” (p. 108).
- 3 Although of course religion generally remains a significant aspect of many people’s lives around the world and those struggling with various forms of chronic conditions, we employ the overarching notion of spiritual geographies of care here due to the ways in which this concept can envelope both religious and spiritual experiences, but refer also to the different landscapes in which such practices can and do happen. This term can signify a diverse set of internal and external resources people can draw on to support their care trajectories and coping needs, involve a spiritual nature to humanity, and a transcendent realm including but also beyond the material world.
- 4 This number is also expected to be an underrepresentation as it does not fully account for a large population of people who feel that are “spiritual but not religious.”
- 5 This is not to ignore the fact that, at an individual level, many biomedically trained health care providers may also be spiritual or religious themselves. There is a difference between a biomedical system (what we often call “scientific” here) as it functions and shapes how health practitioners operate, and that of the belief systems (i.e., spirituality and religions) of health practitioners themselves. Although we are drawing attention to more systemic and cultural aspects of this conversation here, a potential tension between care providers system of beliefs and worldviews and how this relates to those being cared for is another important area to examine in more detail.

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