Spirituality, Mental Health, and Social Support

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Spirituality, Mental Health, and Social Support

A Community Approach

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Foreword

This book is the result of many years of cooperation between the *German Institute for Medical Mission* (DIFÄM) in Tübingen, Germany, and the Department of Practical Theology III of the Faculty of Protestant Theology, University of Tübingen. The cooperation included studies on how congregations can identify resources which can promote health with a focus on accompanying people with depression as well as how congregations can be sensitized to mental health and the needs of persons living with mental disorders. In the collaboration, a close connection between research-studies on the one hand and a congregation-based implementation on the other hand was practiced. In this book, we want to share these results of research and experiences with a more international audience, and put them into a wider, complementary context. We are aware that we cannot consider the whole wealth of related inputs coming from English-speaking sources and we cannot cover the whole discussion, but we would like to make a contribution to the discussion from our particular perspective.

The *German Institute for Medical Mission* (DIFÄM)[1] is engaged in health projects in economically poor countries and in neglected areas. For the work in this field it is of great importance to work in a close and continuous cooperation with local partners. Church congregations and local communities are appreciated for the assets they already have and it is the goal to include the strengths of people in local settings and to link communities to the formal health system. The churches are encouraged to recognize their specific contributions and tasks in the field of health and to implement their healing ministry in various contexts today.

From this point of view, the collaboration aimed at the intersections of health and religion, medicine and congregation. The vantage point of the collaboration between DIFÄM and Chair of Practical Theology III has been to focus on the healing ministry of church congregations and local communities, which does not only make sense in neglected areas of the world but also on the doorstep of the Evangelical Church in Germany, that is, closer to Tübingen, in the Evangelical-Lutheran Church in Württemberg. In light of the differentiation of Church and Religion on the one hand as well as the high-level medical system – especially in a university town like Tübingen – on the other hand, it makes sense in our opinion to link both factors. Because of the complexity of structures, functional differentiation is necessary, but the basic approach of our collaboration was to bring both topics into discussion as they stand in relation to each other.

1 For more information: https://difaem.de/1/home/ (last accessed on 1 April 2020).

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2010–2012 a pilot-project was implemented in Tübingen. This project, in cooperation with Prof. Dr. Gerhard Eschweiler from the Psychiatic clinic and Geriatric Center of the University Tübingen and Dr. Bertold Müller, medical director at the Center for Psychiatry Südwürttemberg, Zwiefalten, had a special focus on depression as an example of mental illness. The purpose was to create a documentation of health resources in church congregations and the promotion of health by congregations using the example of depression. Semi-structured interviews with various groups of people affected by depression, their relatives, volunteers working for institutions caring for people with depression, and volunteers in general were conducted. An online-questionnaire took a closer look at the pastors. Activities in congregations were hosted, workshops for the public were organized, and the results of the survey were evaluated. The experiences and the results of the project were published in 2014.[2]

In 2014 we were given the chance to start the follow-up project "Innovative ways of pastoral care with people with depression" (2014–2015), funded by the Stiftung Diakonie Württemberg. This project was selected as a pilot project for pastoral care (Modellprojekt Seelsorge) by the Evangelical Church in Germany (EKD).[3] As part of this project, we conducted two group-interviews in congregations, and we developed a questionnaire for a quantitative-comparative survey in congregations in Germany as well as in Malawi. We compiled the results of these several surveys in part II (studies).

In the first section of this book, 'Religion and Health. An overview' we present papers from a workshop held in October 2016 in Tübingen which includes Michael Klessmann's lecture on the interrelationship between faith and health from the viewpoint of pastoral care in Practical Theology, and Christian Zwingmann's account of the current state of research in religious psychology. His paper is published in co-authorship with Constantin Klein. Thirdly, Annette Haußmann, who was the project's research assistant, gives insights into the current state of research on spirituality and depression.

As already mentioned, the results of the various surveys are presented in part II. In II.2 (Depression and Pastoral Care from the Viewpoint of Pastors in Germany) we concentrate on and discuss the conclusions of the qualitative interview-study and the results of the online-survey. The results show that pastors are

2 Published as a handbook for congregations: Beate Jakob and Birgit Weyel, eds., *Menschen mit Depression. Orientierungen und Impulse für die Praxis in Kirchengemeinden* (Gütersloh: Gütersloher Verlagshaus, 2014). The project was funded by the Lechler Stiftung and the Evangelical-Lutheran Church in Württemberg.

3 The project was also the subject of research. Kerstin Lammer, *Wie Seelsorge wirkt* (Stuttgart: Kohlhammer: 2020).

contact persons for pastoral care and they are faced with mental disorders in diverse situations, including their professional everyday life at their workplace. However, pastoral care is not only limited to the pastors. Realizing the idea of the priesthood of all believers, volunteers also provide spiritual care. Selected insights from one single interview and one group-interview – presented in the form of two case-studies – are given in II.2 (What Motivates Volunteers in Congregations to Take Care of People with Mental Disorder?). Chapter II focuses on people living with mental disorders and their relatives. This contribution presents results from the individual interviews and points out the special experiences and needs of these people.

A quantitative questionnaire allows for a comparative study concerning Malawi and Germany, two totally different cultural contexts with different medical systems (II.4). The focus on Malawi, where DIFÄM is engaged in health care projects, is also part of the research work of Paul Mekani and Japhet Mbaya who present insights into the knowledge about mental disorder and attitudes towards people with mental disorders among health professionals.

The third section of the book addresses the approaches to improve mental health. In addition to providing new insights and findings, the projects have also been engaged in shifting and shaping church congregations and local communities. An opening chapter gives an overview on mental health in a global perspective (III.1). Beate Jakob introduces the developments in three German congregations resulting from events providing information on and raising awareness for mental disorders including special Sunday services, Bible study-groups and other activities of the local church community (III.2). Vandana Kanth's contribution also covers the promotion of mental health on a local level (III.3). Her focus are the communities in the catchment area of the Duncan Hospital in Raxaul (Bihar/India). The studies from Malawi and India are of interest as such. However, they also serve for comparison and correspond to a comparative approach.

The editors are very much indebted to the contributors of this book and the research assistants in the two projects, especially Stefanie Koch and Dr. Annette Haußmann, as well as the student research assistants at the department of Practical Theology and the interns at DIFÄM. Dr. Andreas Kögel (Bayreuth) served as consultant for the quantitative research. We are also especially grateful for the thorough work of Marianne Schweitzer-Martin and her careful attention revising the texts.

Many people in church congregations and local communities supported our work: Professor Dr. Gerhard Eschweiler (psychiatrist) and Professor Dr. Martin Hautzinger (psychologist) from the University of Tübingen provided valuable advice over recent years, as well as the hospital chaplain Friedemann

Bresch (Tübingen) who was an advisor to the project. The pastors, volunteers and especially the people affected by mental disorders supported us with a great openness.

We received generous funding for our work from the Lechler Stiftung, Stiftung Diakonie Württemberg and the Evangelical-Lutheran Church in Württemberg. We express our sincere gratitude to all who made this work possible.

Last but not least, we thank the editors of this series for admission and the publishing house De Gruyter.

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Contents

Beate Jakob and Birgit Weyel

Introduction

Spirituality, Mental Health, and Social Support. A Community Approach

The relation between religion and (mental) health as a subject of science is multiplex und multi-layered. It has been dealt with in religious psychology, philosophy, medicine and theology for a long time; in the German-speaking context it had a fruitful, interdisciplinary origin and a further development marked by a breaking off and discontinuity in the 20th century.[1] Since the 1990s, a growing interest in empirical research on the relation between religion and mental health has been observed,[2] but there are some problems which inhibit research to a great extent: e.g. the conceptualization of religiosity[3] with its manifold social and psychological dimensions.[4] While religious psychology in the USA is a very lively field of research, the cultural background and the basic conditions of religious practice are very different, so that the religious studies performed in the USA cannot simply be transferred to our German context. Christian Zwingmann and Constantin Klein give insights into the connection betweenreligion and health from the perspective of psychology of religion with regard to the cultural context.[5]

1 Cf. Christian Henning, "Die Geschichte der Religionspsychologie im deutschsprachigen Raum," in *Einführung in die Religionspsychologie*, eds. Christian Henning, Sebastian Murken and Erich Nestler (Paderborn: Schöningh, 2003): 9–90.

2 Cf. Marion Schowalter and Sebastian Murken, "Religion und psychische Gesundheit," in *Einführung in die Religionspsychologie*, eds. Christian Henning, Sebastian Murken and Erich Nestler (Paderborn: Schöningh, 2003): 138–162, 141.

3 Cf. Schowalter and Murken, "Religion und psychische Gesundheit," 143 and Franz Buggle, "Warum gibt es (fast) keine deutsche empirische Religionspsychologie," *Forschungsberichte des Psychologischen Instituts der Albert-Ludwigs-Universität Freiburg i. Br. 73* (1991).

4 Stefan Huber has developed a reliable model for research, which integrates social and psychic dimensions of religiosity (model of centrality); cf. Stefan Huber, *Dimensionen der Religiosität: Skalen, Messmodelle und Ergebnisse einer empirisch orientierten Religionspsychologie* (Bern/Göttingen: Huber, 1996). Cf. also Stefan Huber and Constantin Klein, "Spirituelle und religiöse Konstrukträume," in *Spiritualität transdisziplinär. Wissenschaftliche Grundlagen im Zusammenhang mit Gesundheit und Krankheit*, eds. Arndt Büssing and Niko Kohls (Berlin/Heidelberg: Springer-Verlag, 2011): 53–66. Cf. the overview Constantin Klein, Sonja Gottschling and Christian Zwingmann, "Deutschsprachige Fragebögen zur Messung von Religiosität/Spiritualität. Ein empirisch gestützter Vergleich ausgewählter Skalen," *Spiritual Care* 1.3 (2012): 22–35. Cf. also Mirjam Hoffmann, *Religiosität und psychische Gesundheit* (Stuttgart: Kohlhammer, 2019).

5 Cf. Chapter I.2 in this volume: Christian Zwingmann and Constantin Klein, *Religion and Health from the View of Psychology of Religion: Empirical Results – Possible Pathways – Cultural Context*.

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Nevertheless, in the last decades some studies on the relationship between religion and mental health have been carried out in the German-speaking context as well.[6] Furthermore, under the designation of *Spiritual Care* a remarkable number of studies were published over the last years. Particularly with regard to hospital pastoral care, a strong cooperation between spiritual care given by multiprofessional teams and academic surveys on spirituality can be observed. The SPIR-questionnaire, for example, is a method, which addresses counselling as well as research knowledge with regard to the spiritual needs and resources of patients in health facilities. SPIR – an acronym – consists of a semi-structured interview that focuses on the religious or rather spiritual beliefs (Spirituality), how important these beliefs are for the life of a person, the affiliation to a religious community and the perception of the role of doctors and pastors.[7]

This concept of spiritual care favours an idea of spirituality, which is less focussed on individual religiosity and understands religion in multiple ways in light of multicultural contexts. Traugott Roser points out: "Spirituality is first of all perceived as a difference: as a distinguishing feature among people who would call themselves spiritual but have a very different understanding of the term, not least independent from their religious socialisation and biography."[8]

6 Cf. Annette Dörr, "Religiosität und psychische Gesundheit. Zur Zusammenhangsstruktur spezifischer religiöser Konzepte," *Studienreihe psychologische Forschungsergebnisse Band 80* (Hamburg: Verlag Dr. Kovac, 2001); and Sebastian Murken, *Gottesbeziehung und psychische Gesundheit. Die Entwicklung eines Modelles und seine empirische Überprüfung* (Münster/New York: Waxmann, 1998).

7 Cf. Traugott Roser, *Spiritual Care. Der Beitrag von Seelsorge zum Gesundheitswesen* (Stuttgart: Kohlhammer, ^{2}2017), 391–398. It must be pointed out that the questionaire has been developed in the context of palliative care but it can be taken as an example for a multi-professional approach. SPIR refers to FICA, a guideline, developed by Christina Puchalski's team. FICA represents the main components of the questionnaire: faith and belief, importance, community und adress/action in care. See Christina Puchalski and Anna Romer, "Taking a spiritual history allows clinicians to understand patients more fully," *Journal of Palliative Medicine* 3 (2000): 129–137. See also Christina Puchalski, "Spiritual Care: Practical tools," in *A time for listening and caring: Spirituality and the care of the chronically ill and dying*, ed. Christina Puchalski (Oxford/New York: Oxford University Press, 2006): 229–251. Cf. also René Hefti, "Spiritualität und Medizin. Ein empirischer Beitrag zur Spiritualitätsforschung," in *Spiritualität im Diskurs. Spiritualitätsforschung in theologischer Perspektive*, eds. Ralph Kunz and Claudia Kohli Reichenbach (Zürich: Theologischer Verlag Zürich, 2012): 241–261.

8 "Spiritualität wird dabei zunächst als Differenz erfahrbar: Als Unterscheidungsmerkmal zwischen Menschen, die sich zwar als spirituell bezeichnen, den Begriff jedoch ganz unterschiedlich füllen, unabhängig nicht zuletzt von ihrer religiösen Sozialisation und ihrer Biographie"; Roser, *Spiritual Care*, 399 (trans. Birgit Weyel).

Spirituality is therefore, first of all, experienced as difference: as the differentiating characteristic between humans, who indeed identify themselves as spiritual, however fill the term in very different ways, independently – not only – of their religious socialization and their biography.

The blending of the terms spirituality and spiritual care is helpful when focusing on the individual's beliefs and needs in a multi-professional context, whereas a strict boundary between pastoral care and spiritual care does not make sense.[9] The contribution of Michael Klessmann from the perspective of practical theology's poimenics on the relation between faith and healing shows that pastoral care is already concerned with the overlap of the relevant issues in the field of pastoral care and chaplaincy for sick people.[10] Health as well is not only a medical issue, but has various connections with religion and spirituality, as we would like to show. The approach in this book is to show intersections particularly with regard to religion and spirituality and health, as well as health-care and communities. Below we will introduce this approach to health and community.

Specialization in modern societies is connected with a required differentiation between religion (church) and health (medicine). We do not want to put this into question but would like to show that there is not only a relation between health and spirituality with regard to content, but also that congregations provide support for (mental) health and vice versa: medical facilities can also benefit from a stronger cooperation with congregations. Congregations are complex social entities with connecting factors to medicine, welfare and social work and pastoral care. There might be differences in the health care delivery system for examples in Germany and Malawi,[11] but a community approach to health makes sense here and there. Congregations – so the basic assumption – can contribute to health through providing health-related information and for social as well as spiritual reasons. The concern of this book is the indication of a congregational approach regarding mental health as a helpful addition to other

9 It does not make sense to play pastoral care off against spiritual care and vice versa. Cf. Doris Nauer, *Spiritual Care statt Seelsorge?* (Stuttgart: Kohlhammer, 2015). Cf. also the differentiated statement of Eberhardt Hauschildt regarding similarities and differences: Eberhard Hauschildt, "'Spiritual Care' – eine Herausforderung für die Seelsorge?" *Materialdienst der EZW* 3 (2013): 83–90.

10 Cf. chapter I.1 in this volume: Michael Klessmann, *Does Faith Heal? Reflections on the Complex Relationship of Religion, Illness and Health*.

11 Cf. chapter II.4 in this volume: Annette Haußmann, Beate Jakob, and Birgit Weyel, *Spirituality, Congregational Support and Mental Health – the Example of Depression. Results of a Comparative Study among Volunteers in Congregations and Professionals in Healthcare Settings, Conducted in Germany and Malawi*.

academic initiatives "to promote general awareness among researchers, scholars and professionals of the importance of religious and spiritual issues."[12]

That health is not only a medical issue, has not only been promoted by theology and sociology, but by medicine itself. This position is stated in the definition of health developed by the World Health Organization (WHO).

1 The Definition of Health by the WHO

What is health? Which factors impact health positively or negatively? How can the health status of individuals and of the society be improved? In the middle of the 20th century when the world faced a striking disparity in global health, the World Health Organization (WHO) and the churches put these questions on their agenda. Up to the middle of the 20th century, health had been almost exclusively the domain of scientific medicine and health professionals. Health work was shaped by a static concept of health saying that, "Health is the absence of disease." According to such a narrow understanding of health, healing was mainly restricted to curing diseases. This understanding of health and the corresponding one-dimensional approach to health however was questioned when it became obvious that a curative and institutional-based approach to health alone had not improved global health but instead had led to a striking discrepancy between the health status of people in the industrialized countries and those living in resource-limited countries or regions.

In the constitution of the WHO health was defined as "a complete state of physical, mental, and social well-being and not merely the absence of disease or infirmity."[13] At the same time, the WHO called for access to health for all by stating, "the enjoyment of the highest attainable standard of health – is one of the fundamental rights of every human being."

The WHO definition of health has often been blamed as being utopian. However, this critique is not aware of the definition's true intention: Such a broad view challenges a purely curative approach to health and calls for a multi-dimensional approach. Health is not only a medical issue. This means that in their efforts to improve health in a sustainable way, the governments

12 E.g.: René Hefti and Arndt Büssing, eds., "Integrating Religion and Spirituality into Clinical Practice. Conference Proceedings. European Conference on Religion, Spirituality and Health," in URL: https://doi.org/10.3390/books978-3-03842-929-6 (last accessed on 1 April 2020).

13 WHO, *Preamble to the Constitution of WHO as adopted by the International Health Conference* (New York, 19 June – 22 July 1946).

should apply a comprehensive approach. The medical work offered by hospitals and other health institutions needs to be complemented by considering and addressing the factors contributing positively or negatively to health. These include sanitation, nutrition, safe water and also education and poverty reduction.

But instead of the WHO definition of health influencing health policies of governments, the decades after World War II were shaped by an adverse development. Especially in the industrialized countries, health systems were still marked by an over-reliance on costly medical technology and an over-estimation of the curative approach to health. As a consequence of this prevailing "Western model" of health care, the world faced an ever growing disparity in terms of access to health services and health status between countries and also within countries.

The unjust global health situation also alarmed the churches and the representatives of Christian health care. During the 1960s and 1970s, the World Council of Churches (WCC) in cooperation with the German Institute for Medical Mission (DIFÄM) called for conferences to address this situation and develop new concepts of Christian Health Care. In 1968, the WCC established the Christian Medical Commission (CMC) as its health desk. In their search for alternative concepts for addressing health disparities and improving global health during the 1960s and 1970s, the WHO effectively cooperated with representatives of the CMC. They formed a think tank that developed the concept of Primary Health Care (PHC) presented at the World Health Assembly in Alma Ata in 1978.

With the vision of "Health for All by the Year 2000", the Alma Ata Declaration articulated PHC as a set of principles for the reformation of health services and for addressing priority health needs and the fundamental determinants of health.[14] The Alma Ata Declaration is based on a set of values – equity, social justice, universal access and solidarity – and reveals the following important principles of a comprehensive approach to public health:

- Inter-sectoral approach: With regard to any attempt to improve health, it is recommended to take the determinants of health like sanitation, nutrition, water, education and economic factors into account.
- Participation: PHC is people-centered. Instead of offering interventions in a top-down manner, PHC is a bottom-up approach to health whereby people at the local level are the main actors. It gives space for solutions created and owned by communities which use their own strengths. Individuals and communities have both a right and an obligation to take part in decisions and actions that affect their health.

14 Cf. WHO, *Primary Health Care. Report of the International Conference on Primary Health Care, Alma Ata, USSR, 6–12 September* (Geneva: World Health Organization, 1978).

– Health care is most effective if it integrates health promotion as well as preventive and curative interventions.

In 1986, the WHO Ottawa Charter on Health Promotion[15] resumed the principles of the Alma Ata Declaration and developed the concept of health promotion further. This charter defines health promotion as the "process of enabling people to increase control over, and to improve their health."

Disease prevention addresses the risk factors to health like unhealthy living conditions, drug and alcohol abuse, bacterial and viral infection agents, etc. Health promotion stands for a concept that focusses on strengthening those social and individual factors that have the potential to improve health like conducive work place conditions, physical exercise, healthy diets, life skills, etc. There are of course overlaps between disease prevention and health promotion so that it is not possible to differentiate precisely between the two. However, while preventive measures are mainly to be planned and implemented by the medical system, health promotion is not just the responsibility of the health sector but "is shared among individuals, community groups, health professionals, health service institutions and governments." Moreover, the Ottawa Charter states that, "health is created and lived by people within the settings of their everyday life." Thus, the concept of health promotion clearly counts on individuals and communities to be active partners of the medical system towards improving health of individuals and societies.

Health promotion is a resource-oriented instead of a deficit-oriented approach to health. It corresponds with the concepts of salutogenesis and resilience that today are widely applied in psychology, pedagogy and other social sciences.[16]

The Alma Ata Declaration as well as the Ottawa Charter marked a breakthrough in public health as they broadened the medical model to include social and economic factors and as it put health equity on the international political agenda. In the 1980s, many people and organizations that were active in global health showed great appreciation of this new approach and believed it had the potential to effectively address the global health inequities.

15 WHO, *The Ottawa Charter for Health Promotion. First International Conference on Health Promotion* (Ottawa, 21 November 1986); in URL: http://www.who.int/healthpromotion/conferences/previous/ottawa/en/ (last accessed on 1 April 2020).

16 Cf. e.g. Friedrich Riffer, Elmar Kaiser, Manuel Sprung and Lore Streibl, eds., *Das Fremde: Flucht – Trauma – Resilienz. Aktuelle traumaspezifische Konzepte in der Psychosomatik. Psychosomatik im Zentrum* (Berlin/Heidelberg: Springer, 2018).

However, the concept of PHC was misunderstood from the beginning. It was regarded as an attack on the medical establishment and was confused with an exclusive focus on first-level care. Some people regarded PHC as utopian, and many in the industrialized countries thought PHC was cheap and poor care for poor people – a "second class" health care for people in developing countries while the countries in the Global North were priviledged to enjoy high standard health services offered by well-functioning mostly curative medical services. But, also most governments in low-income countries continued to concentrate their efforts on building up medical institutions offering curative health services. In the 1980s and 1990s, still an optimistic view of the medical approach prevailed all over the world. Development work in the medical field aimed at making high-standard medicine available also in resource-limited settings. It was assumed that scientific medicine would develop even further to finally be able to cure most of the diseases all over the world.

40 years after the declaration of Alma Ata, the WHO reaffirmed its commitment to PHC in the Global Conference on Primary Health Care held in Astana, October 2018. The Declaration of Astana recommends the implementation of PHC as an important contribution to reaching "Health for All". It says: "We are convinced that strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being, and that PHC is a cornerstone of a sustainable health system for universal health coverage (UHC) and health-related Sustainable Development Goals."[17]

2 A Christian Definition of Health

During the 1970s and 1980s, the CMC convened worldwide discussions on the Christian understanding of health, healing and healing community. These discussions reflected the spirit of Alma Ata and brought out a concept of a healing community and congregation which is also of relevance today.

The ecumenical discussions were summarized in the document "Healing and Wholeness. The Churches' Role in Health" which was adopted by the WCC and published in 1989. In this publication, health is defined as "a dynamic state of wellbeing of the individual and the society; of physical, mental,

17 URL: https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf (last accessed on 1 April 2020).

spiritual, economic, political and social well-being; of being in harmony with each other, with the material environment, and with God."[18]

This comprehensive definition of health builds on the WHO definition, but adds some new elements. Health is no longer seen as an individual affair, but the well-being of the individual is seen in direct relation to the way society is constituted. Moreover and very importantly, the CMC definition of health includes the spiritual dimension of health.

Furthermore, this definition assumes that health is not a static concept by which we can distinguish clearly between those who are healthy and those who are not; rather, every person is in constant flux between various levels of maintaining health and fighting infection and disease, hence the term "dynamic state". This kind of process-oriented understanding of health reflects the concept of health promotion.

This Christian understanding of health has consequences for the understanding of the church's mission: It means that, alongside the practices of scientific and also the so-called alternative medicine, churches and congregations have both resources and tasks in the field of health and healing. The document states that "most churches today preach and teach but have abdicated healing to medical professionals. Yet [there are] many ways in which churches are involved in healing."[19]

Faith communities can contribute to health in various ways:

- Congregations are social networks with the potential to turn in solidarity towards sick, lonely, handicapped, oppressed, and marginalized and to those with social problems such as divorce, unemployment, unplanned pregnancy, etc.
- Congregations are places where people come together to worship, to pray for each other, to share about faith, and to commonly search for the meaning of life.
- The congregation is a teaching place by, e.g., facilitation self-discovery of causes of ill health; practical health education; studying questions of biomedical ethics; learning to take personal responsibility for health.[20]

The document advocates for "health in the hands of the people" and explicitly refers to Primary Health Care by stating that "congregations are urged to be involved in and promote primary health care (PHC) as a means of correcting the

18 WCC (World Council of Churches), *Healing and Wholeness – The Churches Role in Health. The Report of a Study by the Christian Medical Commission* (Geneva: WCC, 1990), 6.
19 WCC, *Healing and Wholeness*, 30–31.
20 Cf. WCC, *Healing and Wholeness*, 30–31.

existing unjust distribution of health care resources. Through PHC, persons in all places in the world can be empowered to discover the causes of most of their illness and eliminate them. Through PHC the heavy dependence on professional and institutional health services can be lifted, allowing them to provide more expert care for the complicated illnesses for which they are trained and equipped."[21]

The concept of PHC has offered a huge chance to the churches as they have the infrastructure to implement PHC through their congregations and – as pointed out above – contribute to health through spiritual and social support and provide valuable health information. Thus, churches can be vital partners of the government health system. However, like the governments, up to now the churches all over the world have not been ready to engage in the implementation of PHC on a large scale. Moreover, many churches are no longer very clear about their role in health and sometimes they even consider handing over their health facilities and thus their healing ministry to government health services.

3 The Discussion of the Spiritual Dimension of Health within the WHO

The CMC definition of health approved in 1989 explicitly includes the spiritual dimension of health while the 1946 WHO definition does not mention it. Up to now, the WHO has not amended its definition though there have been repeated inquiries about it. These inquiries reflected the fact that in most cultures health has a spiritual dimension and has always been included in health services.

During the WHO General Assembly in 1983, the participants intensively discussed the extension of the WHO definition of health by including the spiritual dimension. That a WHO assembly put issues of spirituality, which so far had been excluded from the public health discourse, on its agenda was due to the influence of the then WHO General Secretary Dr Halfdan Mahler who was very much open for including the spiritual dimension in the definition of health as well as in health programs. Due to Mahler's efforts, in 1984 the WHO approved a resolution (WHA 37.13) that recommended its member states to include the spiritual dimension in their strategies towards improving health and reaching the goal of "Health for All". Though this resolution was not more than a recommendation, it marked a milestone in the WHO history as it broadens the so far predominantly scientific approach to health by an

21 WCC, *Healing and Wholeness*, 32–33.

immaterial dimension that is not easy to measure and sometimes even difficult to understand and describe.

Only 14 years later, in 1998, the WHO discussed the question of amending the WHO health definition given in the preamble of the WHO Constitution by including the spiritual dimension. A WHO working group drafted resolution EB 101.R2 that suggested the following new definition of health to become part of the Constitution: "Health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease and infirmity."[22] The influence of the CMC definition on this suggested definition of health is obvious in that it mentions the spiritual dimension and regards health as a dynamic state.

Resolution EB 192.R2 again appeared on the agenda of the WHO 52. General Assembly and was discussed intensively. While most representatives of the member states in the Global South strongly supported the definition, some of those speaking for the states in the North, for example the Soviet Union, were hesitant to include the spiritual dimension in the official WHO health definition. They regarded spirituality to belong to one's private sphere instead of being taken into account in the public health discourse. As a result, there was no majority for the amendment of the health definition in the WHO Constitution. Instead, the responsible committee suggested keeping this question on the WHO agenda.

In the years to follow, the question repeatedly came up again, for example in a round table discussion during the 58. WHO Assembly in 2005 (The Round Table Spirituality, Religion and Health 2005). Moreover, in his opening address to the 61. Assembly in 2008, Archbishop Desmond Tutu (South Africa) encouraged the WHO to finally add the spiritual dimension to its health definition. However, up to now the 1946 definition of health has remained the official WHO health definition.[23]

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22 WHO, "Review of the Constitution and Regional Arrangements of the World Health Organization Executive Board 101st Session," EB 101/7 (Geneva: 1997).

23 To the WHO discussions cf. Beate Jakob and Peter Bartmann, "Gesundheit und Gesundheitsförderung. Ansätze zu einer Integration der spirituellen Dimension in Konzepte und die Arbeit der WHO," in *Spiritualität und seelische Gesundheit*, eds. J. Armbruster et al. (Köln: Psychiatrie Verlag, 2013): 48–62; Simon Peng-Keller, "Spiritual Care im Gesundheitswesen des 20. Jahrhunderts. Von der sozialen Medizin zur WHO-Diskussion um die 'spirituelle Dimension'," in *Spiritual Care im globalisierten Gesundheitswesen. Historische Hintergründe und aktuelle Entwicklungen*, eds. S. Peng-Keller and D. Neuhold (Darmstadt: Wissenschaftliche Buchgesellschaft, 2019): 13–72.

4 Today's Health Situation and the Concept of Religious Health Assets

Until today, the medical system has not met the great expectations put to it. In the countries of the Global South many people still lack access to quality health services and essential medicines. The progress that was made in medicine benefitted not all countries and regions equally. Instead, the disparities between and in countries are still there.

But also in the industrialized countries, the health situation and the way health systems work are far from being perfect. For example, chronic diseases including mental disorders are on the rise and many people have to live and cope with them. With regard to chronic diseases, the patient's family also (to varying degrees) take on a share of the responsibility. Society must react to these altered patterns in the progress of disease and has to search for ways to include the sick and the disabled in society and in professional life and to provide care and help beyond cure.

The exorbitant costs of the medical system in the North are another problem that has created a huge challenge for the society. Therefore, the WHO and other global health organizations still strongly emphasize the need to move from a purely curative approach to health to prevention and health promotion.

This situation provides a new window of opportunity to globally think about new approaches to health by including the contribution of communities and congregations. This is an opportunity but also a challenge as we can only encourage congregations to promote health if they know exactly how they can do so.

Churches and Christian communities significantly contribute to health, especially in resource-limited settings. However, Christian health services are not always aligned with the formal health system. While most governments appreciate Christian health services, only a few are ready to allocate an appropriate share of the national health budget to the health work of the churches.

These are just some of the reasons:

- Historically, the churches themselves did not actively seek a close cooperation with the formal health system, especially as long as they had enough funds from other, mostly overseas sources.
- So far, the churches' contribution to health has not been documented properly. Most of their huge health work, especially the work of communities, is literally not "on the map."
- Sometimes, there has also been a problem of communication between governments and the churches. Representatives of the governments might say

that, "these church people are people of good will who do a lot of good. We need them. But nobody knows exactly what they are doing. It's sometimes even difficult to understand them as they use their own faith language."
- Moreover, faith communities themselves often are not aware of what they actually contribute to health.

How then can we understand and document the contribution of faith communities to health? How can we make this contribution known to the communities themselves as well as to the public? These questions led to establishing the "African Religious Health Assets Programme" (ARHAP) in 2001; today known as "International Religious Health Assets Programme" (IRHAP).[24] IRHAP is a collaborative research network based at the University of Cape Town. Its aim is to document the contribution of religion and of religious communities to health, and to align church-based health services with the formal health system.

The introduction of the idea of Religious Health Assets (RHAs) is based on the assumption that religions and religious communities have health related resources, potentials, capabilities, strengths that they own like a financial capital (= an asset) to work with. These assets can be active or they can be there without being used. In the latter case, they need to be activated like a financial asset that is at one's disposal and needs to be invested.

According to IRHAP, faith communities contribute to health because they own "Religious Health Assets" (RHAs). In Biblical terms assets are the "talents" of faith communities that can promote health. These assets or talents can be tangible or intangible.

Tangible or visible health assets of faith communities like the provision of medical services or groups caring for others are well known and appreciated. In addition, faith communities own so-called intangible, invisible health assets. These are rooted in the spiritual dimension and the motivational and mobilizing capacity of faith communities. These assets like trust, motivation, credibility, compassion, mutual support, honesty, prayer, moral authority, etc. can play an important part in fostering the health of individuals and communities. However, as it is difficult to assess these assets and to measure their impact on health, they are often overlooked.

24 URL: http://www.irhap.uct.ac.za/ (last accessed on 1 April 2020).

Within the framework of ARHAP's research programme, a matrix was developed to thoroughly examine the issue of religious health assets from the perspective of the African continent. With some minor alterations, this matrix can also be applied to the European context.

In table 1, the tangible and intangible health assets described above are put along the vertical axis. As both tangible and intangible health assets can have a direct or indirect impact on health, the health assets are put in different positions along the horizontal axis. This then produces four quadrants, which show the health assets and their positive outcomes.

Table 1: Religious Health Assets Matrix.*

Intangible Assets	***Intangible assets with a direct impact on health***	***Intangible assets with an indirect impact on health***
	Prayer Time for sick people Health awareness Being prepared to help Sensitivity to problems ...	Personal sense of meaning in life Social contacts Feeling of belonging to God/other people Openness to social or political issues Hope Trust.
Tangible Assets	***Tangible assets with a direct impact on health***	***Tangible assets with an indirect impact on health***
	Hospitals and Health Centres Care, Counselling, etc. Parish centres that are open to all Room for self-help groups Leisure opportunities for disabled people ...	Educational/training opportunities Choir and other fellowships Religious services providing a structure to the week Sacraments and rituals providing structure in times of crisis ...
	Direct impact	***Indirect impact***
	Positive impact on health	

*Adaptation of a matrix developed by Jim Cochrane. Cf. Jim Cochrane, "Religious Health Assets (RHAs) – Conceptual and Theoretical Framework," in *Religion, Faith and Public Health. Documentation on a Consultation held at Difäm*, ed. Difäm, German Institute for Medical Mission (Tübingen, 9–11 February 2006): 14–45, 24.

Talking about the impact on health, one usually refers to the assets in the bottom-left quadrant of the matrix which are the tangible health assets with a direct positive impact on health, e.g. hospitals, care and counselling groups, etc. These assets can be measured and quantified. Among the tangible health assets having

an indirect impact on health are, for instance, groups that create relationships, like the choir which can also have a positive impact on health, and rituals. These tangible assets are usually not regarded as health promoting, but they often do have a positive impact on health.

The two upper quadrants refer to intangible religious health assets, graded according to their direct or indirect impact on health – like prayer and resilience, which are directly related to health, and a sense of meaning and faith/hope/love which are assets not directly linked to health, but with a major impact on health. These assets are much more difficult to assess than the tangible ones as they are not quantifiable but have to be assessed through qualitative methods.

The RHA matrix was initially designed to demonstrate and document the contribution of faith communities to health with regard to HIV and AIDS. For people living with HIV and AIDS it is obviously very important to have access to treatment and care. But we also know that belonging to a social network as well as having hope and trust affects these patients' physical and even more their mental health significantly.

Rather than being a classification system, the matrix can serve as an eye-opener that helps to widen the understanding of health promotion by faith communities. Health promotion cannot be narrowed down to, e.g., praying for the sick nor can it be restricted to providing space for self-help groups as an example of a tangible health asset with a direct impact on health. Moreover, this concept demonstrates that the genuine contribution of faith communities to health is not a special task, an add-on to what is being done already. The majority of these religious health assets, especially the intangible ones, are an integral part of everyday life of the community. The community as a social network and a place of worship is a healing place in itself.

Looking at the various and specific ways in which faith communities contribute to health also helps to overcome the understanding of the churches' and faith communities' contribution to health being in competition to medicine and the formal health system. Church health services and the contribution to health provided by congregations reflect a holistic approach to health that adds value to the medical approach and cannot be replaced by it.

5 A Holistic Approach to Mental Health

All over the world, the burden of mental disorders is growing. According to the WHO, depression is the leading cause of disability worldwide and a major