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# "Faith-Sensitive" Mental Health and Psychosocial Support in Pluralistic Settings: A Spiritual Care Perspective

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**Abstract:** Over the past two decades, in response to a growing awareness of the impacts of humanitarian crises on mental health and psychosocial well-being, leading UN agencies and international aid organisations have developed a comprehensive framework for Mental Health and Psychosocial Support (MHPSS). In more recent years, aid workers have further begun to consider religious life as a central factor in mental health and psychosocial well-being, viewing "faith" as an important, but often neglected, component of empowering and "locally appropriate" MHPSS. However, the attempt to deliver "faith-sensitive" MHPSS across the highly pluralistic settings of international humanitarian intervention has entailed protracted ethical and practical challenges. In this article, we argue that these challenges may be usefully understood in terms of three areas of concern: the lack of evidence on effective interventions; the risk of reproducing problematic power dynamics between MHPSS providers and receivers; and the challenge of articulating a cross-culturally relevant paradigm of "faith-sensitivity" comprehensible across a wide range of religiously diverse settings. This article contributes to these challenges by drawing on the field of professional spiritual care to suggest areas of potential contribution and interdisciplinary dialogue.

**Keywords:** spiritual care; pluralism; localisation; humanitarianism; Mental Health and Psychosocial Support (MHPSS); faith sensitivity



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## 1. Introduction

Humanitarian emergencies are moments of acute, unmitigated, and often profoundly existential distress. In recognition of this fact, in the early 2000s, the Inter-Agency Standing Committee (IASC), the leading humanitarian standard setting agency of the United Nations, began to develop a comprehensive framework to address the psychological and social well-being of affected individuals and communities. Rather than a narrow logistical and medical problem, it proposed, humanitarian crises have a profound impact on the affected, impairing their resilience and ability to recover. In 2007, this recognition culminated in the formulation of a framework for "Mental Health and Psychosocial Support" ('MHPSS'; IASC 2007). Since its release, MHPSS programmes have been created by major humanitarian actors such as the United Nations Refugee Agency (UNHCR 2018), the United States Agency for International Development (Groves et al. 2021), as well as major non-governmental organisations such as World Vision (Schafer 2010) and the International Federation of the Red Cross (IFRC 2023).

In recent years, aid workers have begun to consider religious life—the pursuit of which is protected by humanitarian law—as a central factor in mental health and psychosocial well-being. "Faith", they argued, is an important but often neglected component of empowering and "locally appropriate" MHPSS provisions which draws on the resources and meaning-making capacities of affected communities, rather than imposing external approaches developed by Western-trained psychologists and psychiatrists (Ager et al. 2019). But "faith-sensitivity", as part of humanitarian interventions made across widely divergent cultural contexts, brought a host of practical and ethical challenges. This article addresses

these challenges by bringing the emerging paradigm of "faith-sensitive" MHPSS into dialogue with the field of professional spiritual care, to explore how spiritual care may help to equip aid workers with the necessary competencies to safely and appropriately implement "faith-sensitive" interventions in religiously plural settings. For present purposes, "spiritual care" is understood as the interdisciplinary field of research, practice and education concerned with ensuring care for the spiritual needs of a given population, particularly in institutional settings such as healthcare, the military, or in correctional facilities. Spiritual care comprises a "wide spectrum of distinctive and occasionally competing models and approaches" (Peng-Keller 2017, p. 175), but is commonly premised on the understanding of "spirituality" outlined by the 2009 National Consensus Project: "spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred" (Puchalski et al. 2009, p. 887).

We begin by situating the appearance of MHPSS amidst the recognition, nascent throughout the 1990s and early 2000s, that humanitarian crises produce significant and largely unaddressed mental health challenges. We then turn to the call for "locally appropriate" MHPSS interventions, and the practical challenges of, and obstacles to, the formulation of "faith-sensitive" MHPSS programmes which emerged in response to it. In the second part, we argue that these challenges may be usefully understood in terms of three areas of concern: the lack of evidence on effective interventions; the risk of reproducing problematic power dynamics between MHPSS providers and receivers; and the challenge of articulating a cross-culturally relevant paradigm of "faith-sensitivity" comprehensible across a wide range of religiously diverse settings. For each, we discuss potential contributions offered by the extant spiritual care literature.

## 2. The Emergence of MHPSS on the Humanitarian Agenda

In the 1980s, the Oxford social anthropologist Barbara Harrell-Bond published a seminal study of the ill-fated humanitarian response to the Ugandan Civil War (1980–1986). Tellingly entitled *Imposing Aid*, it exposed the ill-advised, patronizing, and tone-deaf approach taken by Western aid organisations at the time. Aid efforts concentrated on logistical matters of camp management, and the psychological impact of forced displacement on refugees was barely acknowledged (Harrell-Bond 1986). Only a decade later, with the Balkan War and the influx of refugees to Western Europe, did the mental health aspects of forced displacement become widely acknowledged (Agger 1995, p. 9). Humanitarian crises became widely recognised as producing complex psychological sequelae which are inextricably tied into individual and community resilience and possibilities for political resolution. In this context, the provision of mental health in humanitarian crises was developed systematically.

Initially, efforts focused on the management of mental disorders and "trauma" in refugees (WHO and UNHCR 1996). As reported by Vanessa Pupavac, an International Relations scholar formerly involved with the UN Criminal Tribunal for Former Yugoslavia, by the Kosovo War (1998–1999), an "international therapeutic model" had emerged, with over a dozen international aid agencies, including UN several agencies, "tripping over each other" to offer psychosocial programmes. Many of these were culturally alien and politically disenfranchising and, often, bent on framing entire populations as inexorably "traumatised" and in need of Western psychiatric and psychoanalytic intervention (Pupavac 2002, pp. 489, 499). Mike Wessells (Christian Children's Fund) and Mark van Ommeren (WHO Department of Mental Health and Substance Abuse), for instance, recalled how during the Kosovo War, "a well-intentioned psychotherapist from the U.S. [. . .] set up a counselling tent to conduct therapy for rape survivors. He seemed oblivious to the fact that for a woman to enter his tent would stigmatise her as someone who was raped, as well as raise the risks that she might be killed in order to preserve 'family honour'" (Wessells and Ommeren 2008, p. 200). Peter Ventevogel, a psychiatrist and medical anthropologist at UNHCR charged with developing provisions for psychosocial care, witnessed a "young European psychologist and her urban Pakistani translator attempting to do psychoanalytically informed individual

psychotherapy with bewildered and heavily veiled Pashtun women in a tent on a crowded hospital ground" on a World Health Organization (WHO) mission to Northern Pakistan. On another occasion, a "psychiatrist from a Latin American country had been flown in as part of a medical response team, and could do nothing more than prescribing psychotropic drugs to people he could not understand". According to Ventevogel, "everyone was just trying to do whatever had crossed their minds." (Ventevogel 2008, p. 195).

In response to this situation, in the early 2000s, the Psychosocial Working Group (PWG) was founded by a group of ten leading academic institutes and humanitarian agencies. The PWG began to develop a shared framework outlining a common understanding of "psychosocial interventions", "psychosocial well-being", how well-being is affected in complex emergencies and some principles of good practice (PWG 2003). Its central premise was that humanitarian agencies ought to find out what help is desired by a community and to support it in achieving its own priorities, rather than imposing an external agenda (Strang and Ager 2003). The field, however, remained plagued by fierce debates over the best way to do so, with every organisation pursing an idiosyncratic, and often questionable, approach.

In 2007, the IASC released comprehensive guidelines on the first steps to be taken during emergencies (IASC 2007). The IASC guidelines produced a consensus of 18 UN organisations involved in relief efforts, representing a major milestone which formally incorporated MHPSS provisions as an integral part of humanitarian interventions. As stated by Ventevogel at the time, "these guidelines are not just any guidelines. The fact that they are issued by the [IASC], consisting of the heads of the UN organisations involved in relief efforts, implies that they cannot easily be dismissed as the work of 'some over-involved psycho guys'" (Ventevogel 2008, p. 195). This achievement, wrought by a major group of oftentimes competing UN actors, was not just a political and bureaucratic feat, but added to the "unity and spirit among policy makers, researchers and practitioners alike" (Ventevogel 2008, p. 196), who saw its principles as extending beyond crisis settings to mental health and psychosocial support in low- and middle-income countries in general, as well as to disaster mental health care in the industrialised nations of the global North (Benedek and Ursano 2008; Ventevogel 2008). The IASC committee went to great lengths to emphasise that the affected should be empowered as resilient agents, rather than pathologised and treated as victims. MHPSS interventions should be "appropriate"—the term was mentioned nearly 200 times in the 100-page long document.

The will to ensure that MHPSS is delivered in a way that is "appropriate" to the local context, in a way that does not victimise but empowers its receivers, was inspired by a broader movement within the humanitarian milieu, referred to as the "localisation agenda". Localisation has been a prominent theme in the international humanitarian milieu since the 1990s, when it emerged in response to criticisms that aid agencies displace local capacity to implement their own mandates and agendas, instead of building local capacity in keeping with local realities of crises and the dignity of local people, and that this had led to ineffective and at times counterproductive humanitarian interventions (Aneja 2016, p. 7). While the localisation agenda remains a matter of debate (see Schenkenberg 2016), a large body of literature has emerged demonstrating that "localised" humanitarian responses are more effective and relevant (see Ramalingam et al. 2013; Gingerich and Cohen 2015; El Taraboulsi et al. 2016; ParRD 2016, pp. 8–9). What is perceived as "appropriate" however often widely diverges among aid receivers, and between aid receivers and the typically European and North American aid workers trained in clinical psychology, psychiatry or social work. In the next section, we turn to the emergence of "faith-sensitivity" as an attempt to develop "locally appropriate" forms of MHPPS interventions.

## 3. Faith-Sensitivity and "Locally Appropriate" MHPSS

In 1951, the *Refugee Convention*, drafted amidst advocacy by faith-based organisations, expanded the mandate of UNHCR to the protection of religious belief and practice (Knapp et al. 2013). The *Convention* recognised religion as a reason for persecution, and

guaranteed protections without discrimination for the same. It declared the freedom of refugees to practice their religion and provide religious education for their children, and forbade parties to expel or return refugees when this threatened their life or freedom on account of their religion (*Convention Relating to the Status of Refugees* 1951, Art. 1, 3, 4, 33). Similar stipulations were made in the Geneva Conventions, which defined certain objects used for religious purposes as "relief items", and gave civilian religious figures the same protected status as medical personnel (Marshall et al. 2021, p. 51; Hiebel 1975). The IASC guidelines included a short but explicit call to "facilitate conditions for appropriate communal cultural, spiritual and religious healing practices" (IASC 2007, p. 106). Most recently, the Sphere Project, which publishes a widely recognised handbook on minimum standards in humanitarian response, called for MHPSS provisions which are "socially and culturally appropriate", which is explained with reference to the centrality of "spiritual or religious identity" as an "essential part of [. . .] coping strategy" (Sphere Project 2018, pp. 15–16). From the perspective of international humanitarian law, the protection of religious life and its proactive consideration in MHPSS provisions is well established as a matter of best practice.

Yet, until recently, and much to the frustration of advocates of "locally appropriate" humanitarian work, religion has been widely stigmatised and excluded by international organisations. Kathleen Rutledge, a humanitarian worker, recalled how, about a month after the 2004 Indian Ocean tsunami in Sri Lanka, she was tasked to deliver cookware sets to "people who had lost everything", and met with a Buddhist family sitting in their tent: "they held a picture of their daughter who had been killed and said, 'Where's God?'" Rutledge felt confronted with both how inadequate the help was she could offer in this moment, and how she felt that talking about the most pressing—religious—concern of this family would have been deemed highly inappropriate in terms of her training: "Where is God?"—"well, here's a cooking pot" (Welsh 2020, para. 1–2; Rutledge 2023, personal communication).

Only over the course of the past decade has religion begun to gain prominence on the agenda of the humanitarian milieu, and to figure prominently in the development of empowering and "locally appropriate" humanitarian interventions which are community-led and place the needs and capacities of local civil society at the centre (Sabina et al. 2021). "Faith" has become the preferred term particularly in policy documents and grey literature produced by UN and non-governmental organisations (Walker et al. 2012, p. 118). Shifting the locus of humanitarian responses to the local level has shown that "faith" is inextricably intertwined with humanitarian interventions; from their design to their delivery to how they are perceived by beneficiaries. Accordingly, "faith" is . . .

> [a]t the core of the experience of the vast majority of communities facing crisis and, perhaps as crucially of the majority of national humanitarian agency staff that typically constitute 90 percent of the humanitarian workforce. (Ager and Ager 2011, p. 465)

Faith, the argument went, informs how people cope in times of distress, as well as the decisions people make about their development, their community and their responses to short- and long-term crises (Ver Beek 2000, p. 31; Selinger 2004, pp. 525–39). Pioneered in the 1960s and 1970s by the World Council of Churches (Peng-Keller and Winiger 2022), this approach has been championed by faith-based non-governmental organisations (FBOs) such as Caritas and the ACT Alliance, which have emerged as "leaders in global discussions on localization" (HLA and ICVA 2019, p. 8).

The notion of "faith-sensitive MHPSS" which emerged in this context sought to sensitise humanitarian organisations to this largely overlooked aspect of humanitarian interventions. In 2018, the Lutheran World Federation and Islamic Relief Worldwide, in cooperation with the Church of Sweden, World Vision the Hebrew Immigrant Aid Society, UNHCR and the International Federation of the Red Cross, published an extensive guidance document to provide practical support for humanitarians intending to implement "faith-sensitive" MHPSS programming (French and Fitzgibbon 2018). It outlined a detailed framework to ensure humanitarian responses are coordinated with local faith leaders and

strengthen their participation; consider faith-related aspects in assessment, monitoring and evaluation of humanitarian interventions, and respect the right to the freedom and -expression of faith. It also aimed to ensure aid workers are trained in basic "faith literacy", understood as "knowledge of the tenets, principles and practices of specific religious groups" and a "broader competence in engaging sensitively and knowledgeably on issues of religion with diverse faith communities, including those with which the individual or organization has little previous involvement." (French and Fitzgibbon 2018, p. 9).

The guidelines were closely aligned with the IASC and sought to ensure that MHPSS interventions are sensitive—not based on, but *responsive to*—the faith perspectives and resources of affected communities (Ager et al. 2019; French and Fitzgibbon 2018; MHPSS.net 2018; UNHCR 2018). Since its publication, major multisectoral advocacy groups such as the Joint Learning Initiative on Faith and Local Communities (JLI) and the International Partnership on Religion and Development (PaRD) have launched research and knowledge-exchange initiatives on "faith-sensitive" MHPSS (Abo-Hilal et al. 2023; Arigatou International et al. 2021), and attempts have been made to train humanitarian workers in its application (Fabo 2020; Harsch et al. 2021).

However, as scholars of religion and development have long admitted, religious socialisation may reach both prosocial and profoundly destructive ends. Orientation to the holy, as noted by Scott Appleby in his influential work on the "ambivalence of the sacred", may elicit violent as well as pacifying responses: "at any given moment any two religious actors, each possessed of unimpeachable devotion and integrity, might reach diametrically opposed conclusions about the will of God and the path to follow: violent as well as nonviolent acts fall readily within the range" (Appleby 2000, p. 30). The trepidation of humanitarian organisations to engage with religious actors is often expressed in the call for more evidence for the efficacy of faith as a supportive agent in humanitarian crises. While there is significant evidence that attests to the entanglement of faith and humanitarian processes at all levels, this evidence—even on the account of advocates—remains inconclusive, and religion has been noted as a socioeconomic determinant of health, capable of producing both harmful and protective health effects, playing a "complex" and "contradictory" role in healthcare (Idler et al. 2023; Idler 2014). A recent "state of the evidence" report compiled by a group of leading subject experts associated with JLI prefaced its findings with the following cautionary note:

> If you are seeking the definitive piece of evidence that ultimately proves or disproves whether religions are necessary or important for development, you will not find it in this report. No such evidence exists—no statistic proves religions are conclusively, always, and everywhere, either more or less effective in development interventions. [. . .] The evidence base shows the diversity of religions in development with the evidence base established through many multiples of context-specific examples, from which we can observe key trends. (Wilkinson et al. 2022, p. 12)

Insofar as the role of religion must be assessed anew in each context, the inclusion of "faith actors"—religious leaders, communities and organisations—as a matter of course understandably appears problematic, even if their absence in specific cases may compromise the effectiveness of humanitarian interventions. Advocates of closer cooperation between "faith actors" and humanitarian organisations have responded that the institutional risk–benefit calculus is premised on an instrumental rationality ill-advised as a basis for sustainable and locally owned engagement; that in any case, faith and its interpretations are constantly changing, and indeed, that the secular–religious distinction does not hold historically, and in practice often remains tenuous (Deneulin and Bano 2009; Jones and Petersen 2011; Barnett and Stein 2012).

Including "faith-sensitivity" in MHPSS hence brings a host of practical challenges, in particular the risk of inadvertently promoting behaviour suspected to be dangerous, stigmatising or otherwise "maladaptive coping", contradicting the cardinal humanitarian principle of "doing no harm" (Ager et al. 2019). Certain burial rituals, for instance, may

provide a central source of spiritual support during crises, but create the conditions for worsening the same, as reported during the 2014–15 Ebola response in West Africa, or the burial ceremony of a senior bishop in Montenegro during the COVID-19 pandemic, which sparked a major "super spreader" event (Winiger 2020). Moreover, the role of providers is often unclear; while MHPSS programs seek to empower local communities to draw on their own cultural resources, aid workers are confronted with normative decisions—for example, on the agreement of specific behaviour associated with "local beliefs", such as female genital mutilation, with human rights standards—contravening another core tenet of international humanitarian law, that of impartiality (Ager et al. 2019; Koski and Heymann 2019; van den Berg et al. 2011).

One of the most persistent objections to the involvement of "faith-sensitivity" in humanitarian work bespeaks the fear of exposing vulnerable communities to proselytization. Accordingly, "faith actors" may use humanitarian work to gain access to communities, tie aid to conditions such as church attendance or favour populations which profess certain religious identities. In addition to breaching the humanitarian commitment to impartiality and "doing no harm", this is feared to create or exacerbate existing communal tension and undermine trust in humanitarian actors in the field. MHPSS providers in this sense are caught in a Catch-22. As argued by a group of advocates for "faith-sensitive" humanitarianism:

> While marginalising faith concerns of displaced populations can create harm, over-emphasising the importance of faith to a population or making assumptions about faith needs based on the majority religion may also create harm. Aid should be responsive to persons who both do and do not wish to be engaged in any way with faith. Thus faith sensitivity in aid and MHPSS begins with asking the displaced population: what they believe the causes of their problems are, what they feel the solutions should be and what role, if any, they would like for faith language, faith actors and spiritual practices to be a part of that process. (Rutledge et al. 2021, p. 26)

In practice, MHPSS provisions rarely consider "faith concerns", while local pastoral and spiritual care provisions tend to run "in parallel without integration" into MHPSS services offered by humanitarian actors on the ground (Wilkinson et al. 2022, p. 21). Similarly, Alexander and Letovaltseva, two scholars of spiritual and psychosocial care in military and emergency medicine, argue that MHPSS professionals tend to worry that "faith leaders" may hinder their efforts in some way, while they often lack the language, familiarity with and trust in MHPSS paradigms to cooperate with mental health workers in crisis response. Accordingly, MHPSS professionals have developed three responses: to "adopt or gain competency with religious themes" when caring for religious clients or populations; to "soften religious actors [. . .] to psychosocial concepts in the hope that they will foster higher levels of mental health within their communities", and to "create opportunistic openings in existing psychosocial paradigms to allow religious leaders and/or religious clients to treat religious themes and engage in religious sidebar during broader evidence-based interventions" (Alexander and Letovaltseva 2023, p. 4).

Each response is problematic in its own way. It may reduce integration of religion in MHPSS programs to the acquisition specific competencies by (Western-trained) experts—as if caregivers simply ought to consult manuals as "tourist guides" to the worldview of another (Lartey and Poling 2003, p. 170). The "softening" of religious actors to psychosocial concepts bespeaks a lack of genuine interest in revising pre-existing assumptions, and the perceived need to persuade religious leaders of the efficacy of MHPSS interventions. And the attempt to opportunistically integrate religious aspects into MHPSS interventions in turn demonstrates a complete lack of integration of both approaches. As noted by Alexander and Letovaltseva, "in all three, the unique therapeutic potential that religious themes and religious actors offer is treated as supplemental to the potential of the psychosocial efforts being considered", and the "initiatives developing from all three positions are typically governed by MHPSS professionals, working in accordance with the epistemological frames which undergird the psychological discourse." The "perhaps most telling" expres-

sion of this subordination, they suggest, is found when religious leaders trained as MHPSS professionals use MHPSS to "provide the dominant structure of their arguments" while their religious position "offers supplemental insights" (Alexander and Letovaltseva 2023, p. 4).

## 4. Professional Spiritual Care: Three Contributions

We have briefly introduced the emergence of MHPSS and the nascent recognition of the role played by religion in humanitarian crises, and outlined the practical challenges of, and obstacles to, the attempt to formulate "faith-sensitive" MHPSS provisions. We have identified three issues arising in this context: the complex state of the evidence speaking for the efficacy of including religion in humanitarian responses; the political question of how, and on whose terms, faith is integrated into MHPSS programs; and the challenge of formulating a response both sensitive to spiritual needs and the humanitarian imperative to remain impartial and "do no harm". In the following, we explore potential contributions to these challenges offered by the interprofessional field of spiritual care.

### *4.1. The Call for Evidence*

As with religion in development more generally, the evidence on "faith-sensitive" approaches to MHPSS is relatively thin and recent (Wilkinson et al. 2022). Major disasters such as the Indian Ocean tsunami in 2004, Hurricane Katrina in 2005 and the COVID-19 pandemic have catalysed research (Brenner et al. 2009). However, much of this literature has proceeded on the premise that humanitarian crises wreak "trauma" on affected individuals and entire communities (and "secondary trauma" on care providers), which may be addressed by identifying and evaluating mechanisms of "positive" and "negative religious coping" (Ager et al. 2012; Aten et al. 2019; Captari et al. 2018; Ozcan et al. 2021; cf. Pargament et al. 1998). In this sense, faith-sensitive approaches track the emphasis of conventional MHPSS on post-traumatic stress as a locus for psychopathological intervention (Marshall 2022).

Interestingly, MHPSS professionals interested in "faith-sensitive" care have thus far rarely engaged with the adjacent, interdisciplinary field of professional spiritual care, produced by pastoral theologians, health psychologists, nurse scholars and physicians. This body of research and professional practice, whose emergence over the past two decades has paralleled the rise of MHPSS, has explored new, evidence-based approaches to spiritual care in contexts marked by growing cultural and spiritual pluralism (Anderson and Fukuyama 2004). The "outcomes-paradigm", as this research program is referred to, seeks to move spiritual care from the classical, parochial model of confessional, church-based (and typically white Christian) pastoral care towards a culturally diverse profession recognised as an integral aspect of a holistic healthcare system.

Spearheaded by a generation of spiritual care providers challenged to empirically legitimise their work in healthcare settings, and cultivated by initiatives to promote research literacy among practitioners such as "Transforming Chaplaincy" (Transforming Chaplaincy 2023), this has produced a sophisticated toolbox comprising spiritual needs assessments, best practices and outcome evaluations (Nissen et al. 2020). These are routinely employed by palliative care physicians, healthcare chaplains, and other allied healthcare professionals. In Canada, both the national associations for spiritual care and for counselling and psychotherapy draw on this foundation, with the former certifying "psychospiritual therapists" and the latter training psychotherapists to integrate spirituality into psychotherapeutic work (CASC/ACSS 2023; CCPA 2023). The American Red Cross, which has produced the most comprehensive endeavour to integrate spiritual care into humanitarian response, operates a "Disaster Spiritual Care" procedure in tandem with "Disaster Mental Health", framing spiritual care as a "force multiplier and a partner" to mental health care, acknowledging similarities between both and encouraging collaboration and mutual referral (American Red Cross 2015, p. 19; NVOAD 2014, p. 11, 54; cf. Moses 2022).

While this suggests the feasibility of an evidence-based model to faith-sensitive care as an extension to, and completion of, mental health and psychosocial services, the lack of

engagement by MHPSS providers may be for good reason—other than the widely noted academic tendency to operate within discrete disciplinary niches. Critically, this literature has been developed in relatively affluent, Euro–American institutional care settings, where the primary form of interaction with receivers of care is often that of empathetic listening in the tradition of Carl Rogers (1902–1987), whose work has profoundly influenced the development of Clinical Pastoral Education (CPE). Listening and "being there", interpreted as an expression of the Christian ministry of presence, is well suited to secularised, post-Christian care contexts marked by a high degree of religious pluralism, where funding constraints and the public health imperative to serve all equally favour the assumption of a general spiritual dimension accessible to all without the necessity for elaborate ritual and communal bedding (Sullivan 2014).

In humanitarian crises, particularly in the Global South, this clinical care model, which emerged in Euro–American institutional care settings, may prove impracticable to implement. Though the outcomes paradigm has laid an important empirical and conceptual foundation, MHPSS professionals working with a faith-sensitive approach likely require a new toolbox suitable for rapid deployment across different cultural contexts marked by resource scarcity, sectarian violence and failed institutions. The WHOQOL-SRPB, a quality-of-life measure developed in the 1990s by the World Health Organization in an extensive, cross-cultural consultative process, may be a possible point of departure for the development of practicable spiritual need assessments which are appropriate across a wide range of humanitarian crises (Winiger 2022). Similarly, the five-item Patient-Reported Outcome Measure (PROM), developed in the Scottish National Health Service as a patient-centred evaluation of spiritual care interventions (Snowden and Telfer 2017), may serve as a basis for the development of an assessment instrument suitable for the evaluation of faith-sensitive MHPSS interventions in certain humanitarian settings.

### *4.2. Colonial Legacies*

In the mid-1970s, the group of 77 countries (G-77), a multilateral lobby group associated with the United Nations Conference on Trade and Development (UNCTAD), succeeded in passing a decisive resolution at the UN General Assembly. It called for the development of a "New International Economic Order" and aimed to overturn a global system of trade thought to favour the Global North (Alden et al. 2010). Though its political impact soon faded, the resolution brought the legacy of colonialism to the forefront of UN agencies such as WHO (Chorev 2012). As demonstrated by the ongoing struggle of religious leaders to be involved in decision-making processes affecting their communities, however, colonial dynamics remain. They are evident in the routine attribution of religiosity to the Other—underdeveloped, provincial and poor—and the insistence that religious realities prove their worth by the standards of clinical psychology to warrant inclusion in humanitarian assistance. Insofar, the call for "faith-sensitive" MHPSS ought to be read as a critique of an ongoing colonial legacy of epistemological and political disenfranchisement.

To complicate matters further, providers of "faith-sensitive" care have themselves been deeply implicated in colonial dynamics of power. Beginning in the 1960s, the (Christian) colonial legacy became subject to extensive self-reflection, when two conferences held by the World Council of Churches and the Lutheran World Federation (later dubbed Tübingen I and II), produced a consensus on the new role of the church's medical mission in the post-colonial area (Flessa 2016). More recently, spiritual care scholars have read pastoral theology with a post-colonial and feminist critical lens, critiquing the genealogies of violence which have accompanied Christian notions of care (Moon 2023; Moon and Lartey 2022; Sharp 2013, 2019); pointing out pervasive misunderstandings between religiously motivated care givers and receivers (Sharp 2013); exposing the patronizing and patriarchal imagery of pastoral metaphors (Lartey and Moon 2020), and the enduring postcolonial dynamics in pastoral leadership, liturgical celebration and interfaith collaboration (Pui-lan and Burns 2016).

Historical awareness and critical self-reflection in this vein have thus far seemingly eluded attempts to integrate "faith-sensitivity" into MHPSS provisions. The account of

Alison Schafer, a clinical psychologist formerly at World Vision International, is instructive. Schafer recalled World Vision's response to the Haiti earthquake, and its attempt to ensure access to "religious and cultural support" and help the population conduct mourning rituals in accordance with IASC recommendations (IASC 2010, p. 6). According to Schafer, World Vision was "approached by many Western-based church groups and publishing organisations" with "materials that they believed would be helpful to support the spiritual and mental health well-being of congregations and other communities in Haiti". But "while some aspects of the materials were potentially beneficial, such as encouraging children to talk with others about their feelings, or to use mediums such drawing or diarising their unhappy thoughts, many also suggested simplistic approaches to complex issues." They encouraged children to pray, confess sins and follow Jesus Christ, or suggested that "based on group discussion topics alone, church communities may be able to lead and support people affected by loss and grief, domestic violence or rape" (Schafer 2010, p. 126). As this illustrates, "faith-sensitivity" may be positioned as a corrective to the imposition of culturally alien concepts of care—but if mistakes of the past are to be avoided, the considerable theological literature on post-colonial pastoral theology may offer valuable insights.

### *4.3. Interreligious Dialogue*

Indeed, the political dimension of care begins with the very term used to refer to this undertaking: "faith". The guidelines on "faith-sensitive" MHPSS define "faith" as describing "a specific religious tradition or affiliation and the beliefs associated with that tradition or affiliation". But the authors profess "sensitivity to the fact that a pre-eminence of personal belief in defining religion privileges a certain tradition of Christian theology," and acknowledge that "the term religion is now in increasingly wide use" (French and Fitzgibbon 2018, p. 9). Indeed, the Lutheran and Reformed soteriology of salvation by faith (*justificatio sola fide*) has been most widely influential in evangelical communities of the global North (Vainio 2017; Sproul 1999).

But from a global perspective, "faith" represents but one existential orientation among many. To the extent that "faith" is understood in terms of belief associated with a specific religious tradition or affiliation; it is difficult to translate into other cultural contexts. As pointed out by E. E. Evans-Pritchard (1902–1973) in his classic study of the Nuer, a Nilotic ethnic group home to South Sudan and parts of Ethiopia, there is no linguistic equivalent to the notion of "belief" in their language. One may say *kwoth a thin*, meaning "God is present", when challenged with a difficulty, but this does not mean, in the contemporary English sense of the word, that "there is a God". "That", argued Evans-Pritchard, "would be for Nuer a pointless remark. God's existence is taken for granted by everybody. [. . .] There is in any case, I think, no word in the Nuer language which could stand for 'I believe'" (Evans-Pritchard 1956, p. 9). Rodney Needham (1923–2006), another prolific Oxford social anthropologist, has shown that the Nuer are no outlier. On the contrary, missionary translators have gone to great lengths to translate "belief", at times contorting awkwardly to find a suitable expression even for simple biblical proclamations, such as on the belief in "good news" (Mark 1:15) (Needham 1972, p. 188).

The ramifications of not reflecting on this terminology are potentially far-reaching. As Lartey and Moon stated bluntly, "when we limit what is 'spiritual' to 'faith' traditions, it reinforces Christian hubris: a combination of white Christian superiority as normative, with racism intertwined in those standards of the norm" (Lartey and Moon 2020, pp. 2–3). If left unquestioned, the "Christian hubris of the zero point", though intended to care, may subtly perpetuate a colonial legacy of "curative violence" (Moon 2023, p. 26). In Sahrawi refugee camps in South-West Algeria, for instance, religious self-representations have been reported to be strategically used to negotiate humanitarian aid:

> In this context, 'faith' emerges as part of a fluid and ever-evolving script which is reflexively engaged and projected by Sahrawi actors according to the perceived priorities and expectations of diverse donors. Given the constantly shifting donor

> audiences in the camps, including European 'secular' humanitarians, Muslim members of Algerian civil society, and American evangelists, multiple public performances must be presented and managed 'on-stage', just as a variety of 'hidden transcripts' will be enacted, debated and contested 'off-stage' [. . .] in the absence of non-Sahrawi observers. (Fiddian-Qasmiyeh 2011, p. 535)

The notion of "faith", in the sense of a commitment to a set of propositional statements made in view of a range of ontological possibilities, has been subject to critique by scholars seeking to establish interreligious dialogue (Aitken and Sharma 2017; Smith 1972). Among spiritual care scholars, the privileged role assumed by "faith" and related (white protestant) Christian terminology has been noted since at least the 1980s, giving rise to a sizeable literature interrogating the unspoken assumptions, theological underpinnings and linguistic misunderstandings entailed in offering spiritual care across cultural borders (Grung 2022; Lartey and Poling 2003; Noth et al. 2017; Weiss et al. 2021).

As the colonial legacies of care are rethought, so has the language moved away from pastoral metaphors towards concepts reflective of indigenous notions of existential ultimacy. The aspiration has moved on from attempts to develop "cultural competence" —the attainment of expert knowledge on the subject of care—towards a stance of "cultural humility", understood as an invitation to "lifelong learning, listening and self-reflection" on the self in relation to the other (Klein 2020, p. 34; Tervalon and Murray-Garcia 1998). As one post-colonial pastoral theologian was advised by a neighbour before her service in the U.S. Peace Corps: "If you're invited into basket-making at midnight, say yes" (Sharp 2020, p. 96). As part of CPE training, spiritual care professionals are thus educated to serve religiously diverse communities and develop strategies to navigate religious pluralism in public institutions (Cadge and Sigalow 2013). A considerable literature has emerged on this, particularly regarding North American healthcare settings (Liefbroer et al. 2017), and guidance on how to provide spiritual care in religiously pluralistic settings is offered by initiatives such as the Chaplaincy Innovation Lab and the Society for Intercultural Pastoral Care and Counselling. By engaging with this literature, "faith-sensitive" MHPSS may be developed as an empowering and cross-culturally relevant concept.

## 5. Conclusions

Humanitarian crises have "diverse effects on the mental health and psychosocial wellbeing of affected populations" (Tol et al. 2023, p. 969). As such crises are becoming increasingly frequent, complicated and protracted (OCHA 2023), it is likely that demand for effective MHPSS programming will increase. As this article has highlighted, MHPSS has been a focus of the humanitarian sphere for over a decade, and, with the 2007 IASC Guidelines, has become a recognised as an important aspect of humanitarian intervention. The growth of MHPSS emerged in conjunction with the rise of the localisation agenda, which emphasises the importance of "locally appropriate" interventions. By shifting the focus to the local level, the intertwinement of "faith" with mental health and psychosocial well-being becomes unavoidable. For many, "faith" is the lens through which they understand the world, their place in it, their decisions and how they experience stress and other mental health and psychosocial challenges. In response, the guidance for "faith sensitive" MHPSS was developed to ensure that MHPSS remains in keeping with the lived realities of individuals and communities affected by humanitarian crises.

In this article, we have argued that "faith-sensitive" MHPSS, however, has encountered a number of practical and ethical challenges. "Faith-sensitivity" is not a magic bullet for more effective MHPSS provision in humanitarian contexts, and while "religion" is inextricably intertwined with mental health and psychosocial well-being, it has the potential to create protracted problems for humanitarian responses. Humanitarians respond to crises in diverse contexts in different countries and communities across the globe, where religion is lived and embodied in radically plural ways. As a result, the opportunities and challenges posed by "faith-sensitivity" can differ from context to context. The context-specificity of religious life makes a one-size-fits-all approach to "faith sensitive" MHPSS problematic.

We have outlined three key areas of challenge and suggested potential contributions made by the interdisciplinary field of spiritual care.

Firstly, the potential for local faith actors to harm mental health and psychosocial well-being and the relatively thin evidence base on "faith-sensitive" MHPSS has led to repeated calls for evidence about how to safely and effectively operationalise a "faith-sensitive" approach. While the clinical care model, which emerged in European and North America professional spiritual care, may not be directly applicable to humanitarian contexts, it has provided a foundation of empirical evidence for their work in healthcare settings in recent decades, in particular methods for assessment and outcome evaluation used in settings marked by religious pluralism. These could provide a point of departure for the humanitarian sphere as it develops its understanding of faith-sensitive MHPSS.

Secondly, we have pointed out the colonial and medical legacies that have been subject to extensive self-reflection and -critique. Beginning in the 1960s, this has been taken forward by spiritual care scholars who have brought pastoral theology into dialogue with post-colonial and feminist critical theory. To avoid past mistakes, this considerable literature could provide vital insights on how the humanitarian sphere can contend with its own colonial legacies and position "faith-sensitive" MHPSS as a corrective to, rather an than extension of, culturally alien concepts of care.

Finally, spiritual care scholars have long grappled with, and educated for, the delivery of spiritual care in religiously pluralistic settings. As humanitarian organisations are often working in varied contexts and diverse religious communities, it is critical that a "faith-sensitive" MHPSS paradigm is developed through interreligious dialogue, in a way that is equitable and cross-culturally relevant and can cater for the diverse spiritual, mental health and psychosocial needs of local actors and communities. We have proposed to begin this discussion with an earnest, critical interrogation of the term "faith" by MHPSS providers. As the humanitarian sphere continues to develop it's understanding of "faith-sensitive" MHPSS, the field of professional spiritual care may offer an important and thus far largely untapped resource.

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