Spirituality and psychosocial work in emergencies: four commentaries and a response

Grace R. Onyango, Michael Paratharayil, Simon van den Berg, Relinde Reiffers, Leslie Snider & Cynthia Erikson

The commentaries on the next few pages relate to the article 'Spirituality and mental health in humanitarian contexts: an exploration based on World Vision's Haiti earthquake response' by Alison Schafer on page 121–130 of issue 8.2 of Intervention (2010). The author uses the experiences in the aftermath of the Haiti earthquake to substantiate her argument that nongovernmental organisations do not have a clear set of interventions to address the spiritual needs of an affected population, in conjunction with their mental health and psychosocial support needs. The author considers this a gap, given the evidence that spirituality can have beneficial effects on mental wellbeing, and is often an important resource for both coping and coming to terms with the consequences of events. However, as mentioned in the editorial of issue 8.2, blurring the line between psychosocial support and 'spiritual support' could lead to promoting specific religious values to distressed populations, and may even be seen as proselytising of vulnerable groups. The dilemma surrounding this uneasy relationship between religion and psychosocial work definitely warrants further exploration and discussion.

This issue, therefore, contains four commentaries responding to the issues raised in Schafer's article. Grace Onyango, an experienced psychosocial specialist from Uganda, believes that spiritual approaches are not necessarily at odds with more standardised mental health and psychosocial support interventions. In her experience, providing spiritual nurture is not the same as evangelism and deserves more attention in humanitarian work. Michael Paratharayil, who works with a faith based, nongovernmental organisation, underlines the importance of using (local) religious ritual as part of interventions aimed at improving the psychosocial wellbeing of survivors. He illustrates this with examples from South East Asia. Simon van den Berg, Relinde Reiffers & Leslie Snider, who are staff members of the War Trauma Foundation, acknowledge the need for all humanitarian workers to be sensitive to people's religious and spiritual beliefs, as they should be for social values and cultural practices, in general, but question whether this warrants the creation of specific 'psycho-spiritual approaches,' and the development of separate models and guidelines. Cynthia Erikson, a psychologist with the Fuller Theological Seminary, underlines the importance of facilitating both the discussion and practice of what people believe, and to try to understand of how these beliefs relate to the experience of an emergency and its aftermath. She advocates the use of an existing clinical tool, the Cultural Formulation, that can guide clinicians through the various ways that culture (and this could include religion and spirituality) is embedded in diagnosis and treatment, and that this can assist the process of developing appropriate interventions. In her response, Alison Schafer points out that she does not recommend developing tools that narrowly focus only on spiritual nurturance and mental health and psychosocial support, but rather to seek ways to include spiritual nurture more broadly within humanitarian work. A first step is the

Debate
Intervention 2011, Volume 9, Number 1, Page 61 - 73

ongoing consideration of the pervasive influence of spirituality on wellbeing, and the ways humanitarian agencies can support all aspects of wellbeing, for the survivors of emergencies.

Keywords: mental health, psychosocial support, mental health and psychosocial support (MHPSS), spirituality, spiritual nurture, psycho-spiritual, faith

Spirituality: a neglected resource in humanitarian work

Grace R. Onyango

I would very much like to thank Alison Schafer for her paper on the need for spiritual nurture in emergency situations. I have always wondered why an area that is an essential part of people's culture and way of life, is so often neglected within interventions. I also wonder why this topic seems so difficult to discuss, and generates tension and sometimes ridicule, among aid workers. The lack of evidence based research, proving that it works, fuels arguments for not taking spirituality seriously. However, this not a convincing reason to me. Humanitarian practitioners often accept and respect non-evidence based practices. For example, in Uganda aid workers respect, and to some extent encourage, the belief and practice of the Acholi people of stepping on raw eggs as a ceremonial symbol of purification and forgiveness. Yet, humanitarian professionals can be very reluctant to give the same positive and encouraging attitude to using Christian practices.

Spirituality can bring inner peace to affected individuals, and consequently mental wellbeing. This may not be *'empirical'* in the scientific sense, but that is not a good enough reason to neglect it. Spirituality should, in my opinion, be given proper attention and focus, as recommended by Schafer. It is an important resource for people and it can *'hold them together'* at their most vulnerable time. When people face adversity, they may automatically find solace in turning to God.

'Spirituality is not something we need to pump into our children as though it were nitrous oxide at the dentists. Like oxygen it is freely available to each of us at every moment of life. Spirit is in every breath we draw and so is spiritual nurture' (Fitzpatrick, 1994, quoted in Youst et al., 2006).

People do not need to be told, nor forced, to do this. People seek to understand what is happening, often beyond human explanations. For example, it is often beyond human explanation for an individual to understand why other people died, yet he/she survived.

My reaction focuses on two points: firstly, whether spiritual approaches are at odds with more standardised mental health and psychosocial support interventions; and secondly, the notion that providing spiritual nurture may amount to using aid to promote particular religious views. I will restrict myself to the use of *'spirituality'* and not use it synonymously with *'religion.'* The term *'religion,'* which is composed of beliefs, rituals and practices, tends to elicit some resistance and hardness of heart to those who do not take it as important in a person's life.

We need first to understand '*spirituality*.' Spirituality goes deeper than simple human understanding; what connects one with their deity occurs at a deeper level, beyond simple human interaction. A study by the Center for Spiritual Development Institute in Childhood and Adolescence (Roehlkepartain, 2008), documented what youth in 17 countries, in different parts of the world, said about what spirituality meant to them;

'*Being spiritual is knowing yourself*' (Gaurav, India);

'*Being spiritual is believing in things that are not real, intangible, that cannot be perceived by our senses, but that you know exist*' (male, 14. Peru).

Spirituality is actually an inner resource that helps a person cope. The best that humanitarian aid workers can do is to work with local religious leaders to provide spiritual counselling and guidance in a culturally appropriate way, and to help the person to reconnect with their deity for answers that may not be readily provided anywhere else.

I believe the core of spiritual nurture is to help to provide meaning to life, and thereby also provide hope for the future. Hope thrives in the midst of emotional and mental stability, supported by the surrounding environment in which the person lives. Irrespective of *what* people believe, if they find meaning in life, and have hope, this will positively affect their mental health, wellbeing and the desire to survive. Spiritual nurture and mental health and psychosocial support (MHPSS) interventions have to be provided hand in hand, considering the person's history and how the individual's response to the current event presents. A person may reconcile himself/herself spiritually with what happened, and yet that person may still have mental health issues, such as lack of sleep or eating disorders, that require tailored interventions. The family and the community (including faith leaders) should continue to give the necessary support to protect against emotional disorder by providing coping options, but at the same time, mental health providers should assess and act on cases that may require tailored interventions. A person who is in distress requires holistic support. Segmenting human needs and prioritising some needs over others may actually cause more harm than good. I wonder what happens when people, who are used to turning to spiritual practices in times of adversity, are assisted by international humanitarian workers with predefined ideas about what is needed? If aid workers fail to assist vulnerable people to connect with their spirituality, are we not thereby precipitating mental problems?

Spiritual nurture could be very basic, for example, providing space for people to have some time of reflection with their God, and not to be burdened with undue questions or overprotection. It can also include encouragement to hold on to what they believe in, and not to lose hope. People to draw strength from the reading of holy books and other spiritual literature, and it is important to facilitate access to these resources.

My second point relates to the concern that Schafer expresses about what would happen when faith based organisations offer psycho-spiritual support to people of their own faith only. Indeed, this would present an ethical issue, as it may be discriminatory. In the aftermath of emergencies, one role of faith based organisations (such as World Vision) could be to inform and educate others about the importance of providing spiritual nurture to the affected population. Such nurture should be provided as is practiced, in the faith of the survivors. All organisations should work with local spiritual leaders to ensure that people receive spiritual nurture in their own way.

Of course, faith based organisations should not compromise their values. They should declare who they are, and do what is ethically

best and in the interest of all survivors, without losing their identity. Spiritual nurture is not the same as evangelism. It should help to reinforce resources that are already present within the affected individuals, families and communities. As in any situation, there may be some people who will be influenced, or inspired, by the way faith based organisations do their work. However, that is not a reason *not* to do this work!

This leads, naturally, to the issue of the lack of appropriate psycho-spiritual materials for use in emergency situations. I believe it is not possible to create universal materials. Every situation is unique, due to differences in culture and beliefs. We need to develop frameworks through which spiritual nurture and MHPSS could be provided, but not to develop the content of these materials. Aid workers should listen to the local population and respond according to their needs, as far as is possible, and involve them in decisions regarding the form of spiritual nurture to provide.

Grace R. Onyango holds a Masters Degree in counselling psychology and is a psychosocial consultant. She worked with World Vision International (Uganda) from 2002 to 2008. email: robonyango@yahoo.com

Psycho spiritual interventions in psychosocial care

Michael Paratharayil

The article by Alison Shafer highlights the need to integrate psycho-spiritual dimensions into humanitarian interventions. While I appreciate the overall conceptual frame-work, I am unsure whether it is appropriate to use the terms '*religion*' and '*spirituality*,' synonymously. While religion implies rituals and religious practices (while facilitating spiritual development), spirituality expresses more of a '*state of wellbeing*.'

It should be important to identify certain religious practices, within the context of disasters that strengthen psychosocial well-being. In any case, it is important to identify and prioritise certain types of cultural practices that are embedded in religious beliefs. Each religion has its own practices when it comes to the rituals associated with death, grief and bereavement (Parkes, Laungani & Young, 2003). For example, my experience of working in Sri Lanka has highlighted the importance of designing religious rituals as part of psychosocial interventions (Paratharayil, 2005). After the Tsunami, some community members felt guilty that they could not give last rituals for the dead, nor the subsequent memorial services within one month of their deaths. People from all four main religious groups in the country; Buddhists, Christians, Hindus and Muslims, felt the need to organise such rituals and memorial services. It was also important in ensuring the wellbeing of the survivors, as there were rumours of '*souls wandering around*' in the villages. Some community members were even afraid to go out '*fearing for ghosts*.'

The need to organise some rituals was prioritised during focused group discussions. This resulted in designing interventions with some national secular organisations that were funded by a faith based organisation, as part of the early psychosocial interventions.

I would like to share and discuss the experiences in the Philippines after typhoon Durian (Reming) in Bicol in 2006. During discussion with the community members at the evacuation centres, two weeks after the typhoon, some community members said they were afraid to go out at night. They heard screaming and crying, and some expressions, such as; *'it is not yet the time for me to die'*. The common perception was that *'dead souls were wandering around'* in the villages. Within focus group discussions, it was revealed that none of the dead had received their last rituals. Both Catholic and Muslim Philippinos believed that the last rituals would have helped the departed souls to rest in peace. Memorial services, such as a memorial mass and a blessing of the sites where people were *'buried'* under the rubble, as well the sites of landslides, would have given the survivors the feeling that they carried out their obligations to the departed souls. Organising these rituals involved financial resources, and some planning. Most of the survivors did not have resources, nor were they in a mental state to carry out the planning. National non-governmental organisations (NGOs), with funding of a faith based international NGO (INGO), organised these community rituals and memorial services in different locations in Legazpi town, as part of the early psychosocial interventions. There were no *'hidden religious agendas'* in these interventions. This project was implemented and managed by national, secular, NGOs. A total of 1800 people benefited directly from these interventions. During the service, there were opportunities for the community members to share their grief and to listen to the experiences of others.

> *"The sharing facilitated by the religious leaders helped the surfacing of fear, state of shock, grief after the loss of family members and relief to some when they were under the shock of the destructive typhoon. The blessing of the missing and the buried victims at the site had, at least, alleviated some of the negative feelings and pessimism about the future; some felt that they were able to recognise the healing power of spiritual interventions"* (Cope Foundation and Coastal Core, 2007).

The impact of these interventions had a profound impact on the communities. During focus group discussions, the community members reported that after having organised the memorial services, they never heard the crying or screaming in the night again. Though it is hard to verify these observations, it is clear how significant religious rituals were for the psychosocial wellbeing of the survivors. The positive impact of psycho-spiritual interventions, especially in the Buddhist transcendental meditative methods, was also observed in Burma/Myanmar after Cyclone Nargis in 2008 (Paratharayil, 2010).

Michael Paratharayil works as the regional emergency manager for Central and South East Asia, and the Middle East in the Humanitarian Division in Christian Aid, London. He has completed his Ph.D. in public health. He has also managed humanitarian and disaster risk reduction programmes in more than 20 countries in Asia and Africa.
email: michaelparath@gmail.com

Debate
Intervention 2011, Volume 9, Number 1, Page 61 - 73

A '*psycho-spiritual approach*': beyond the mental health and psychosocial support humanitarian mandate?

Simon van den Berg, Relinde Reiffers & Leslie Snider

Alison Schafer (2010) wrote an intriguing exploration about the relation between religion, spirituality and humanitarian intervention in what she calls '*spiritual nurture*' and '*psycho-spiritual*' approaches to mental health and psychosocial support (MHPSS) in emergencies. The article also raises the question of policy relevance, and the need for guidance in psycho-spiritual approaches for all humanitarian actors and organisations, faith based or not. Additionally, the article discusses both the advantages of psycho-spiritual, faith based MHPSS approaches, as well as cautionary tales about their effectiveness and appropriateness in humanitarian settings, judging them according to international guidelines (IASC, 2007) and codes of conduct (IFRC/ICRC, 1994).

In our team at a non faith based, psychosocially focused NGO, the article provoked a discussion on some basic questions about the spiritual and religious aspects of human recovery from terrible events, and what this might mean to our approaches. In particular, is the Schafer article recommending – by coining the phrase '*psycho-spiritual approach*' and by advocating additional guidelines – to create a new discipline within our existing MHPSS humanitarian frameworks? Will this add value to existing frameworks, or will this add unnecessary complexity and intrusion into natural, personal and communal healing paths?

In reflecting on this issue, we would like to further explore the following questions:

1. What are we really talking about when we use the terms: '*religion, psycho-spirituality, MHPSS*'?
2. What does it require of us, as psychosocial, humanitarian aid workers?
3. What should we do about it?

What are we really talking about?

In the MHPSS field, we have faced challenges in finding a term, phrase or definition to describe the spectrum of what we do and '*believe in,*' particularly in gaining legitimacy with '*non believers*' amongst our humanitarian colleagues. We have worked a long time to demystify and label processes that are very personal and intimate in their nature, and that relate to feelings, beliefs, thinking and capacities, during times of great human suffering or in the face of inhumane experiences. Even while we work to simplify and explain what it is we do, it is useful to keep in mind that our work with the '*psyche*' of people and communities, finds its roots in '*spirit.*'

Although Schafer initially provides separate, clear definitions of '*religion*' and '*spirituality*',

she chooses to lump them together in her discussion of the diverse traditions and beliefs within the Haiti context. We think differentiation is needed. In our view, '*religion*' refers to a system of beliefs and practices, and involves membership in an organisation or group with specific rules of observance and conduct for the members of their community. We feel '*spirituality*' involves the personal ways people appraise their lives and the world, attribute meaning and value, relate to themselves, their '*deity*' or other people, and strive for balance in their souls, as well as peace of mind. Religion is one of many vehicles for the realisation of one's spiritual life, and may also serve other functions related to social and political order, beyond an intimate spiritual relationship.

Both religiousness and spirituality are used to understand and attribute meaning to life situations, and can be particularly relevant for people facing major life events such as conflict or disaster. Making meaning of life itself is an important human process in growth, development and recovery from stressful life events, whether or not people ascribe to a '*religious*' or '*spiritual*' identity. Personal reflection may, or may not, acknowledge religious or spiritual dimensions – it is not solely within those domains.

What does it require of us, as psychosocial, humanitarian aid workers?

Another question that the Schafer article raises for us is whether or not the available evidence supporting religious and spiritual nurturance and mental wellbeing is a sufficient argument to create a new paradigm within the framework of humanitarian action? All humanitarian action, by definition, has to recognise and deal with religious or spiritual diversity. Humanitarian workers and helping activities will certainly be more effective when they demonstrate sensitivity and empathy to people's religious and/or spiritual beliefs, social values, feelings and cultural mores. However, the creation of '*spiritual nurturance*' or '*psycho-spiritual approaches*' to MHPSS implies something further; a new discipline or paradigm that would lead to development of models, guidelines for do's and don'ts, and perhaps even necessitate judgment of the quality and appropriateness of some local practices and traditions.

This is potentially dangerous territory. Are we in a position to recommend religious or spiritual dimensions to healing and recovery, in the same way we advocate exercise, getting enough rest and avoiding excessive alcohol? Even what seems like simple and practical advice – '*talk to loved ones about your experience*' – is laden with cultural and social complexity within various contexts, and reveals itself to be grounded in more '*Western*' ways of behaving.

Schafer's well thought out recommendations raise important issues, such as how to encompass and honour various beliefs and religions, and to adhere to the simple existing rules of conduct that guard against furthering political or religious agendas of certain groups. However, the recommendations begin to read like the basis for a new set of guidelines that she feels may be needed for this newly defined field. For example, she suggests that '*agencies wishing to partner with local churches and spiritual nurturing activities need to assess the MHPSS needs in those communities and congregations*,' and suggests that faith based agencies, in partnership with local religious groups, ascertain where they would like to focus in the Inter-Agency Standing Committee (IASC) intervention pyramid.

These recommendations require careful consideration, as they also imply a need for standards by which to judge the quality of religious and spiritual organisations, and the appropriateness of partnerships with humanitarian organisations based on inclusion and neutrality. How will we judge what is appropriate and effective among the range of possible belief systems and practices in these circumstances? What about the role of traditional healers or fundamentalist organisations? In a personal example, one of the authors worked in a psychiatric hospital on a Navajo reservation in the U.S. One night, a young female patient was involuntarily admitted for violently attacking her family. The family, however, was vehemently opposed to her admission to the hospital and insisted she be released for a *sing* (ceremony) to be performed by the medicine man. How could we, as mere mental health professionals with the limitations of our own training and paradigms, be able to judge the potential impact of this intervention, its quality, its appropriateness and its safety for this patient?

Furthermore, the creation of a new paradigm or framework of '*spiritual nurturance*' or '*psycho-spiritual MHPSS approaches*' may have other consequences. The inherent tenets of religious traditions and spiritual beliefs can potentially be a great asset in collective recovery (providing a framework for creating meaning, hope, transcendence and restoring social bonds). However, they can also be a detriment where those tenets are in conflict with personal journeys of recovery, understanding and meaning from traumatic events, or where people do not share religious backgrounds. Therefore, faith based humanitarian organisations by *communicating their faith based character or origin,* might be at some risk of counter-effectiveness in providing MHPSS interventions.

Schafer further mentions the risk of exclusion and discrimination. All humanitarian organisations want to avoid the potential danger of imposing a value or belief system that may not resonate within the local culture, or may even hamper the restoration of treasured rituals and practices. For example, forgiveness and reconciliation, as values often felt to have religious origins, can be interpreted and applied in strikingly different ways in different contexts, such as the aftermath of natural disaster versus post conflict settings characterised by organised violence (e.g., territorial occupations, genocide, gender based violence).

What should we do about it?

Considering such dilemmas fully brings to the fore the real task of realising our own implicit values as humanitarian workers or organisation, and the equal, opposite risk of ignoring the spiritual and religious dimensions in our work. The question for our team remains, however, what should we do about this issue, if anything? Are new guidelines, models, paradigms and assessments needed? Are we taking on too much responsibility for judging and vetting appropriate models for social behaviour and healing within world contexts? What exists within our professional knowledge and good practice models that can inform this issue?

Careful assessment of religious and spiritual beliefs and practices is indispensable to mental health and psychosocial support work, particularly in achieving its claims to healing and recovery of individual and collective levels. We need to be aware of these dimensions, to understand how communities are locally organised, not only as

an informed entry into these community structures, but as a necessary ingredient in establishing helping contact with people in need, and thereby provide appropriate support to individuals and groups healing in the aftermath of extreme events. However, we also feel that awareness of these dimensions is less a matter of religious or spiritual competence, than of good humanitarian and clinical therapeutic practice.

For guidance, we feel we need look no further than our own professional or clinical skills training, competence training in intercultural relations and good humanitarian practice (Hofstede & Hofstede, 2004). A clinical skill training involves awareness of, and setting aside, one's biases in order to meet individuals, wherever they may be found. Competence in intercultural communication situations prioritises meeting others as individuals, and not primarily as representatives of a different culture (risk of apriori stereotyping), or requiring detailed knowledge of the beliefs within different cultures. In a similar vein, good humanitarian practice necessitates an understanding of people in their current context, with neutrality and with respect for their needs and priorities. Perhaps we are really talking about the ways in which we encounter people, in vulnerable situations and in the midst of huge changes in their own reality, without judgment and without prescribed notions of how that person will find their way to recovery.

In sum, we thank Alison Schafer for her thoughtful writing of an issue that has myriad dimensions in local humanitarian contexts. Her article served as an important reminder to us of the need to reaffirm existing professional ethics of *do no harm*, and good practice guidelines that inherently relate to our interface with myriad personal and local healing paths, especially those relating to *'religious and spiritual nurture'*. There is a value in the brevity and simplicity of the existing guidelines and practice principles that we need to review and emphasise, while avoiding guidance that may limit, misinterpret, exclude or misunderstand beliefs and processes outside our realm of expertise.

Simon van den Berg is a social psychologist, retired senior trainer/consultant, now volunteer project monitoring at the War Trauma Foundation.
Email: s.vandenberg@wartrauma.nl
Relinde Reiffers is a cultural anthropologist, humanitarian assistance MA, and programme officer at the War Trauma Foundation.
Leslie Snider is a psychiatrist, MD, MPH, and head of programmes at the War Trauma Foundation.

Debate
Intervention 2011, Volume 9, Number 1, Page 61 - 73

Incorporating religious and spiritual needs into psychosocial programmes

Cynthia Erikson

Alison Schafer's (2010) article, '*Spirituality and mental health in humanitarian contexts: an exploration based on World Vision's Haiti earthquake response*' offers an insightful set of questions for the aid community to consider when it seeks to respond to the spiritual needs of a community in crisis. She also risks articulating issues of ethical practice, and personal or organisational agendas that need to be part of the dialogue. This response offers some points of challenge, as well as proposed tools for the ongoing task of developing interventions that can be relevant for a specific religiocultural context.

A first point of challenge is our tendency to use the terms '*religion*' and '*spirituality*' as synonymous. While I understand the reasons why we, as mental health professionals, do this, there are ways that this contributes to the confusion of boundaries and roles for care professionals. We can talk about a mental health or psychosocial programme wanting to contribute to the '*spiritual health*' of a person; in this way we are suggesting that any individual has the potential of spiritual awareness or a sense of something that transcends her or himself (whether that be nature, ancestors, spirits, God, gods, or another sense of divine). However, when the term '*religion*' is added to the conversation, there is a particular set of beliefs, rituals, doctrines, and behaviours that can be associated with a particular religion, with a particular history, in a particular cultural context today.

Another point of challenge is to look specifically at the boundaries of service or care. If a faith based organisation wants to '*engage in the spiritual nurture*' (Schafer, 2010), would that only be in a general framework of acknowledging the spiritual dimension of community life? Or would leaders from various religious groups in the community be asked to facilitate certain practices? We must be careful that we do not dissect certain practices from their religious or spiritual roots and '*prescribe*' them as mental health interventions. The practice is part of a system. For example, in the study of coping in Tibetan Buddhists who were torture survivors, meditation was discussed only within the context of Buddhist philosophy as a whole (Elsass & Phuntsok, 2009).

For the last 20 years, I have been learning and teaching within a context that emphasises the '*integration*' of psychology and theology. Since its founding in 1965, The Graduate School of Psychology at Fuller Theological Seminary has been training mental health professionals to consider religious and spiritual strengths, and risks, within their ethical and evidence informed treatment of clients. While the training model at Fuller is based on the American Psychological Association's model of accredited programmes, I believe that there are some tools that may be helpful in formulating models for incorporating religious

and spiritual needs in psychosocial programmes.

First, at the risk of being too simplistic, I believe that the role of mental health and psychosocial interventions is to facilitate the conversation and practice of what people believe, and to increase the understanding of how these beliefs intersect with their experience of the crisis in their community. This is different from, *telling people what to believe*, or *prescribing spiritual practices* as an intervention. One way to conceptualise this difference is to consider the benefit of creating a spiritual narrative (Wilson & Moran, 1998). What did the individual, family, or community believe about the world, the divine, or spirituality prior to the crisis? How were those beliefs enacted in the local context? What were the beliefs during the event? What have been the beliefs and behaviours after the event? This is a type of assessment, but it is also a type of intervention. Allowing the story to be told can create an opportunity to identify how these beliefs and rituals may have contributed to resilience, and how they may be further utilised. A narrative such as this may also reveal ways that religious or spiritual beliefs and behaviours have contributed to harm that the community has experienced.

Another tool which may be beneficial to the development of interventions, is the framework of the Cultural Formulation (American Psychiatric Association, 2000) which has five sections outlined to guide a clinician through the various ways that culture is embedded in diagnosis and treatment. We could adapt this existing formulation to generate hypotheses about how religiocultural context may be considered, and integrated into psychosocial interventions. The model of the cultural formulation is consistent with the *IASC Guidelines* (IASC, 2007) description in *Action Sheet 5.3* on collaborating with local religious leaders to understand the religious and cultural meaning of the community event and necessary healing.

The formulation begins with the designation of the *'cultural identity of the individual.'* Religiocultural identity is more complex than simply a stated religious tradition; it can mean many different things depending upon the intersection of other identity issues: ethnicity, culture of origin, region, gender, sexual orientation, disability, etc. So, while we need to ask the general question of the religiocultural identity (or identities) of the community, we also need to ask whether there are subgroups that may have different experiences or identities.

Next, the cultural formulation requires that the clinician identify *'cultural explanations of the individual's illness.'* How does the religiocultural identity inform the community's perspective of what is wrong? Does the community believe that the earthquake is Allah's punishment? Does a family believe that God rescued them from their attackers, but feel guilty and burdened for not fighting back? It is important to recognise how deeply embedded religious ideals or doctrines can be in the definition of tragedy and its aftermath. Particular individuals, families, or communities may also hold beliefs that are not normative within the local, larger religiocultural context.

The third section of the cultural formulation is *'cultural factors related to psychosocial environment and levels of functioning,'* and mental health professional needs to evaluate the unique religious network that may be available to the community, family, or individual within that. Is this network a support system? Who is the leader? What activities or rituals are available to respond to the community's pain? Is the religious

community actually contributing to the problems? Has the religious community been damaged by the impact of the crisis? Is the loss of this religious network an added stressor, rather than a source of resilience? Does the religious community facilitate a care giving network, and/or does responsibility within the religious group burden the members?

One area of the Cultural Formulation, which may often be overlooked, but is critically important is the *'cultural elements of the relationship between the individual and the clinician'*. This section asks the caregiver to consider the ways that their own background may interact with the background of the client and cause challenge or benefit. Does the psychosocial worker have a similar religious background to the local community? What benefits might there be in similarity? Or, what problems might there be if the expectation of similarity limits the ability of the worker to hear differences? Does the worker or organisation represent a different background from the community? What might be the benefits of this difference? Also, what limits might there be? The worker (and organisation) needs to consider how his or her own perspective on religious practice may interfere. Do they hold a strong belief against certain practices? Do they inadvertently disparage the intensity of the local religious beliefs? The organisation also needs to consider the ways that donor expectations might play into this aspect of assessment and planning. Does a donor expect certain practices or the emphasis of certain beliefs? How will the organisation manage the possible discrepancies?

The final section of the cultural formulation is the *'overall cultural assessment for diagnosis and care'*. This pulls the insights from the sections above into a *'plan'*. What is the overall identified need or issue? What is the plan to incorporate the local traditions? What is the unique religious perspective of that particular community, family, or individual? The plan can address ways that certain religiocultural stressors, or points of concern, may be addressed through certain religious practices or rituals performed by local religious leaders and facilitated by the organisation (IASC, 2007). Additionally, the religiocultural factors can also be identified as key sources of resilience or recovery, and adapted into specific interventions for that community. Or, there may be advocacy needed regarding the messages of certain religious leaders that may not represent the broader religious tradition.

Certainly the work is complex. It may be impossible to develop materials that can address religiocultural issues in broad ways. However, Schafer's (2010) article recognises the importance of at least creating standards for organisations to follow in order to engage in holistic care in a manner that allows for spiritual needs and resources. This response is a voice of encouragement, and an attempt to offer a few tools for the work ahead. At the core, we should remember that mental health and psychosocial care could help communities identify and talk about WHAT they believe, rather than telling them what TO believe.

Cynthia B. Eriksson, PhD Clinical Psychology, MA Theology, is an assistant professor of psychology at the Graduate School of Psychology, Fuller Theological Seminary, 180 North Oakland Avenue, Pasadena, CA 91101, USA. email: eriksson@fuller.edu

References

American Psychiatric Association (2000). Outline for cultural formulation and glossary of culture bound syndromes, Appendix I. In *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision, pp. 897–903). Washington, DC: American Psychiatric Association.

Cope Foundation and Coastal Core (2007). Update report on Typhoon Reming/Durian Psycho social interventions, April 2007 (Unpublished report submitted to Christian Aid).

Elsass, P. & Phuntsok, K. (2009). Tibetans' coping mechanisms following torture: An interview study of Tibetan torture survivors' use of coping mechanisms and how these were supported by western counseling. *Traumatology, 15,* 3-10.

Hofstede, G. (2001). Culture's Consequences, Comparing Values, Behaviors, Institutions, and Organizations. Thousand Oaks CA: Sage Publications.

Hofstede, G. & Hofstede, G.J. (2004). *Cultures and Organizations: Software of the mind.* New York: McGrawhill USA.

Inter-Agency Standing Committee (IASC) (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva: IASC.

Paratharayil M. (2010). Basic versus focused psychosocial interventions for community wellbeing: lessons following the Nargis cyclone interventions in Burma/Myanmar. *Intervention, 8*(2), 148-157.

Paratharayil, M. (2005). Life After Disaster - Mental and Social Health Care after Tsunami, *Health Exchange*, May, 24-27.

Parkes, C. M., Laungani, P. & Young, B. (2003). *Death and Bereavement Across Cultures.* Brunner-Routledge, New York.

Roehlkepartain, E.C., Benson, P.L., Scales, P.C., Kimball, L. & King, P.E. (2008). *With their own voices: a global exploration of how today's young people experience and think about spiritual development.* Minneapolis, MN, USA: Center for Spiritual Development in Childhood and Adolescence Search Institute.

Schafer, A. (2010). Spirituality and mental health in humanitarian contexts: an exploration based on World Vision's Haiti earthquake response. *Intervention, 8,* 121-130.

Youst, K. M., Johnson, A. N., Sasso, S. E. & Roehlkepartain, E. C. (eds) (2006). *Nurturing Child Adolescent Spirituality: Perspectives from the World's Religious Traditions.* Lanham: Rowan & Littlefield publishers.

Wilson, J. P & Moran, T. A. (1998). Psychological trauma: Posttraumatic stress disorder and spirituality. *Journal of Psychology and Theology, 26,* 168-178.