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The Ethics of Cultural Competence Training with Reference to Faith Practices and Spirituality

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Introduction

The concept of cultural competence in medical care and behavioral health care is expanding exponentially to include awareness and skills not only relating to traditionally-framed cultural differences but also to such things as gender-complex diversity, workplace violence, HR compliance, use of inclusive language, proper use of AI, encouragement toward L2 (Second Language) learning, and so much more. The concept also takes on overtly subjective dimensions when it stretches beyond gaining knowledge and awareness to promoting intense forms of self-examination of one's perceptions, values and truth-conceptions, alongside the expected measurements for it (e.g. Loftin et al., 2013). Competence has even become linked to such matters as social justice, with a view to promoting equitable access to medical care and behavioral health care. Add to that individualization for (sub-) cultures (e.g. Purnell, 2013) and the concept's proportions have become behemoth.

Undoubtedly, cultural competence is an essential component of both effective medical care and behavioral health care. Consequently, this paper takes a selective look at two facets of cultural competence, taking a cue from the American Counseling Association's (ACA) ASERVIC Standards (see Sec.2.F.2.g) with respect to a long-recognized but shifting feature of competency which has morphed into multiple dimensions: specifically, what has long been handled broadly under the term "religion" now requires distinguishing between religion, spirituality and faith practices – a conceptual outlook held by increasing numbers of people, particularly younger adults, and one that must be reckoned in both medical and behavioral health care situations. There is a profound shift taking place in Western society (at the very least) that reconfigures how people are configuring themselves in relationship to faith and its related practices, and this calls for a competence configuration that is suitable to these shifting worldview standards.

With these factors in mind, this paper argues three points: a) that spirituality, faith practices and religion are determinants of physical and mental health outcomes; b) that there are ethical and legal imperatives for respecting and becoming competent in spiritual, and religious, and faith practices; and c) that clinician – patient relationships, rapport and communication enhancement can be based on these competencies.

Based on Snowdon et al. (2017) systematic review, clinical supervision improves the effectiveness of care and patient experience by fostering reflective practice, skill development, and professional growth. Inasmuch as supervision is a proven driver of better patient outcomes, it follows that the content of supervision and training should include the full spectrum of competencies necessary for high-quality, patient-centered care, and this includes cultural competencies in spirituality, faith practices, and religion. These dimensions often shape patients' values, health decisions, coping mechanisms, and perceptions of how professional care should proceed, making them integral to establishing client/patient rapport. Without structured training in these areas, new medical and mental health care professionals may overlook critical aspects of patient identity, resulting in miscommunication, diminished trust, and poorer health experiences. Incorporating spiritual and religious cultural competence into early professional education ensures that future clinicians not only gain technical proficiency but also develop the interpersonal and cultural sensitivity shown to enhance patient satisfaction and health outcomes.

The Emerging Distinction: 'Spirituality', 'Religion,' and 'Faith Practices'

The emerging trend is unmistakable: fewer than half of Americans today report attending church services regularly, with millennials and those younger even less so. On the other hand, as church-based involvement drops, two out of five Americans report that they are becoming "more spiritual," according to a 2024 Gallup Survey. These (and related) statistics show that religion, rather than disappearing, is morphing into increasingly individualized experiences of spirituality.

Thus, we have utilized definitions and guidance from the American Medical Association (AMA), American Psychological Association (APA), National Association of Social Workers (NASW), and the American Counseling Association (ACA) / Association for Spiritual, Ethical, and

Religious Values in Counseling (ASERVIC) and make this central observation: the concepts of spirituality, faith practices, and religion, while related, are distinct and carry important implications for culturally competent care. The AMA defines spirituality as the ways individuals seek and express meaning, purpose, and connectedness, and which may or may not involve theistic beliefs (AMA Code of Medical Ethics, Opinion 1.1.3). The APA similarly describes spirituality as a broad construct reflecting personal beliefs and values that inform a person's worldview, distinct from formal religious affiliation (American Psychological Association [APA], 2017). In contrast, faith practices refer to specific rituals, observances, and moral behaviors, such as prayer, fasting, or dietary laws, which those individuals engage in as an expression of their beliefs (National Association of Social Workers [NASW], 2015). Religion, as noted by both the NASW and the ACA/ Association for Spiritual, Ethical, and Religious Values in Counseling [ASERVIC] (2015), is an organized system of beliefs, symbols, and worship practices, often shared within a community and shaped by institutional structures. While religion often provides the framework within which faith practices occur, spirituality is a broader, more individualized phenomenon that may transcend or exist outside of organized religion. Recognizing these distinctions aligns with ethical obligations across the AMA, APA, NASW, and ACA standards to respect and incorporate clients' spiritual and religious values into care in a manner that is sensitive, individualized, and free of coercion.

Over the past several decades, Western societies have experienced a marked paradigm shift in how individuals conceptualize and engage with the sacred, moving from a dominant framework of institutional religiosity toward more personalized, subjective and differentiated understandings of spirituality, faith practices, and religion. Historically, religiosity was often synonymous with formal affiliation, doctrinal adherence, and participation in organized worship (Putnam & Campbell, 2010). However, sociological and psychological research demonstrates a growing trend toward "spiritual but not religious" identities, reflecting a desire for personal meaning-making and transcendence outside of traditional religious structures (Pew Research Center, 2021; Zinnbauer et al., 1997). Spirituality has increasingly been defined as an individual's pursuit of meaning, purpose, and connectedness to self, others, nature, or the divine – and this holds whether or not it is rooted in a specific creed (Koenig, 2012). Faith practices, by contrast, encompass the concrete rituals, moral disciplines, and devotional acts – such as meditation, fasting, or pilgrimage – that express one's beliefs, either within or outside organized religion (Fetzer Institute/National Institute on Aging Working Group, 1999). Religion, while still salient, is now more narrowly understood as an organized system of beliefs, moral codes, and community-based worship, often mediated by institutional authority (NASW, 2015; ASERVIC, 2015). This perceptual shift reflects broader trends in secularization, globalization, and cultural pluralism, creating a more complex spiritual landscape in which healthcare and behavioral health providers must discern and respect these distinctions to deliver ethically and culturally responsive care.

Given the social paradigm shift from traditional religiosity toward more individualized expressions of spirituality, faith practices, and religion, medical and mental health professionals can no longer assume that a client's or patient's belief system aligns with a particular religious affiliation or standardized set of practices. The diversity of contemporary spiritual identities – especially including those who identify as "spiritual but not religious" – means that assumptions based on appearance, cultural background, or demographic indicators risk misrepresentation of a patient's values and needs (Pew Research Center, 2021; Zinnbauer et al., 1997). The American Medical Association (AMA Code of Medical Ethics, Opinion 1.1.3), the American Psychological Association (APA, 2017), the National Association of Social Workers (2015), and the American Counseling Association's ASERVIC, (2015) all emphasize the ethical responsibility to respect and accurately understand a patient's beliefs, particularly when these beliefs influence healthcare decisions, treatment adherence, or coping strategies. Evidence-based assessment tools such as the FICA Spiritual History Tool (Puchalski & Romer, 2000) and the HOPE questions framework (Anandarajah & Hight, 2001) provide structured, non-judgmental approaches for eliciting information about a person's spiritual beliefs, practices, and resources. Such tools help clinicians identify distinctions between spirituality, faith practices, and religion, ensuring that care plans are culturally responsive, patient-centered, and free from bias. This approach not only upholds professional ethical standards but also strengthens trust, communication, and health outcomes.

Thus, the challenge before educators today is to acquaint medical and mental health care students with the importance of these assessment points in preparation for their encounters with clients and patients who require these levels of cultural competence.

Spirituality, Faith Practices and Religion as Determinants of Physical and Mental Health Outcomes

The contemporary distinctions between spirituality, faith practices, and religion have significant implications for both physical and mental health outcomes. Decades of research demonstrate that these domains can serve as important protective factors or, in some contexts, sources of distress that influence disease progression, treatment adherence, and recovery (Koenig, 2012; Oman & Syme, 2018). Spirituality, understood as the search for meaning, purpose, and connectedness, has been associated with reduced stress, greater resilience, and improved coping in chronic illness populations (Pargament et al., 2011). Faith practices, including prayer, meditation, fasting, and community worship, have been linked to physiological benefits such as lowered blood pressure, enhanced immune function, and improved pain tolerance (Seeman et al., 2003). Likewise, religion – when experienced as supportive and community-oriented – can provide a sense of belonging, moral guidance, and tangible resources that enhance both psychological well-being and physical health outcomes (VanderWeele et al., 2016). These findings highlight the necessity of integrating nuanced spiritual

and religious assessments into health care to fully understand the non-medical determinants of patient well-being.

Beyond direct health effects, spirituality, faith practices, and religion profoundly shape patients' health-related behaviors and decision-making. Religious and spiritual frameworks often guide views on medical interventions, end-of-life care, mental health treatment, and preventive health behaviors (Puchalski et al., 2014). For example, certain religious traditions aim to influence decisions regarding blood transfusions, organ donation, reproductive health, and/or dietary choices, while personal spirituality may shape attitudes toward complementary and integrative medicine. Mental health research similarly shows that spiritual well-being is inversely correlated with depression, anxiety, and substance misuse, while religious community involvement can buffer against loneliness and suicide risk (Bonelli & Koenig, 2013). However, not all spiritual or religious experiences are beneficial; negative religious coping, spiritual struggle, and/or exclusion from faith communities can exacerbate psychological distress and worsen outcomes (Exline et al., 2014). This complexity reinforces the importance of distinguishing between spirituality, faith practices, and religion in clinical encounters rather than treating them as interchangeable constructs.

Taken together, these domains function as powerful, multifaceted determinants of health, operating through psychosocial, behavioral, and even biological pathways. The AMA, APA, NASW, and ACA/ASERVIC, all emphasize that ethical, culturally-competent care requires understanding and respect for these dimensions as integral parts of a patient's identity. In a healthcare environment increasingly shaped by pluralism and personalized care, failing to assess for these factors risks overlooking critical influences on treatment engagement, recovery, and quality of life. Conversely, integrating spiritual and religious competencies into medical and mental health practice allows providers to address the whole person – body, mind, and spirit – in ways that align with a patient's values and ultimately can promote the potential for better health outcomes.

Ethical and Legal Imperatives for Respecting and Becoming Competent in Spiritual, Religious, and Faith Practices

Building upon the recognition that spirituality, faith practices, and religion are integral determinants of health, it becomes evident that healthcare providers have both ethical and legal responsibilities to address these domains with competence and respect. Ethical imperatives are grounded in professional codes such as the American Medical Association's Principles of Medical Ethics, which mandate that physicians respect patients' beliefs, values, and cultural backgrounds in all aspects of care (American Medical Association, 2020). Similarly, the American Psychological Association (APA) and the National Association of Social Workers (NASW) emphasize cultural competence, explicitly including religious and spiritual diversity as key dimensions of client identity (APA, 2017; National Association of Social Workers, 2021). These standards affirm that ignoring or inadequately addressing a patient's spiritual or religious worldview may not only compromise care quality but also risk violating ethical principles of beneficence, autonomy, and respect for persons. From a legal perspective, frameworks such as the U.S. Civil Rights Act of 1964 and related anti-discrimination statutes require institutions to provide reasonable accommodations for sincerely held religious beliefs, further reinforcing the necessity of practitioner competence in navigating these domains.

In mental health and medical contexts, this competence extends beyond tolerance to proactive engagement, which includes accurate assessment, respectful dialogue, and integration of spiritual or faith-based resources when appropriate and desired by the patient. The Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) outlines specific competencies for addressing spiritual and religious issues in therapy, highlighting skills such as self-awareness of the provider's own belief systems, knowledge of diverse traditions, and the ability to apply this understanding in culturally responsive care (Cashwell & Watts, 2021). These competencies align with the ethical duty to avoid imposing one's own beliefs while ensuring that patient preferences inform treatment planning. Moreover, failure to honor these preferences can carry legal consequences in cases where neglect of spiritual needs results in perceived discrimination or inadequate care, particularly in faith-sensitive contexts such as hospice, palliative care, or mental health crises.

Ultimately, the ethical and legal imperatives for integrating spiritual, religious, and faith practice competence into healthcare practice converge on the principle of patient-centered care. As healthcare systems embrace models emphasizing personalized medicine and holistic well-being, the integration of spiritual and religious dimensions is not an optional enhancement but a core requirement for quality care delivery. Respecting and skillfully engaging with these aspects of identity safeguards patient rights, strengthens therapeutic alliances, and can improve adherence and health outcomes. For a diverse and pluralistic society, this approach not only fulfills professional and legal mandates but also affirms the dignity and wholeness of each individual being served.

Clinician–Patient Relationships, Rapport and Enhanced Communication Can Be Based on Those Competencies

The competencies required to address spirituality, religion, and faith practices in health care not only fulfill ethical and legal imperatives but also serve as a foundation for strengthening clinician–patient relationships. Cultural humility and spiritual competence foster trust, which is essential for effective therapeutic alliances (Hook et al., 2013). When clinicians demonstrate genuine respect for patients' belief systems and integrate these values into care planning, patients are more likely to perceive their providers as empathetic, understanding, and aligned with their personal goals (Puchalski et al., 2014). Such rapport is associated with improved patient satisfaction, higher adherence to a treatment regimen, along with a greater willingness to disclose sensitive health information – thus, altogether enhancing both clinical accuracy and patient outcomes (Rakel et al., 2011).

Effective communication rooted in these competencies also addresses potential barriers that may arise from misunderstanding, mistrust, or lack of values congruence between patient and provider. Spiritual assessment measurements, such as the FICA Spiritual History Tool, offer structured ways to initiate dialogue about beliefs, values, and practices that may influence care (Puchalski & Romer, 2000). These structured approaches help clinicians avoid stereotyping while still allowing space for individualized expression, ensuring that spiritual and religious considerations are integrated authentically into decision-making processes. Moreover, a relational approach informed by these competencies encourages shared decision-making, in which patients feel their moral, cultural, and spiritual frameworks are respected in the selection of treatment options (Elwyn et al., 2012).

Incorporating these competencies into everyday clinical practice has a cumulative effect, reinforcing a care environment that values the whole person – body, mind, and spirit. As trust and rapport deepen, patients are more likely to engage in open, honest communication, even when discussing challenging topics such as prognosis, end-of-life care, or ethically complex interventions. By grounding relationship-building in spiritual and religious competence, clinicians can navigate these sensitive discussions with greater cultural sensitivity, emotional intelligence, and relational attunement, ultimately enhancing the quality of care and promoting improved health outcomes (Koenig, 2012; Sulmasy, 2002).

The Challenge to Train Medical and Mental Health Care Students

Preparing future medical and mental health professionals to competently address spirituality, religion, and faith practices presents both pedagogical and institutional challenges. While professional organizations increasingly emphasize these competencies, the integration of such training into curricula is often inconsistent, fragmented, or relegated to elective coursework (Koenig, 2012; Peteet & Balboni, 2013). Effective preparation requires not only didactic instruction but also experiential learning opportunities that allow students to apply concepts in real-world contexts. This includes embedding spiritual and cultural considerations into clinical supervision, where students receive guided feedback on their ability to assess, respect, and incorporate patient belief systems into care planning (Shafranske & Pereira, 2004). Such supervision fosters reflective practice, enabling students to examine their own values and potential biases while learning to engage diverse patient populations ethically and respectfully.

Structured cultural competency courses represent another essential pedagogical strategy. These courses, when grounded in evidence-based frameworks, move beyond awareness-raising to develop practical skills in communication, rapport building, and collaborative decision-making (Campinha-Bacote, 2011). Including modules on spiritual assessment tools, interfaith perspectives, and case-based learning allows students to navigate the nuanced intersections of health care and belief systems. Furthermore, integrating content on negative religious coping and spiritual struggles ensures that future providers are prepared to address not only the benefits but also the potential harms associated with certain religious or spiritual experiences (Exline et al., 2014).

Ethics courses also play a critical role in preparing students for the legal and moral complexities that arise when spiritual or religious beliefs intersect with medical and mental health care. Topics such as patient autonomy, informed consent, and reasonable accommodations for religious practices are essential for fostering ethical reasoning (APA, 2017; AMA, 2020). When ethics instruction is coupled with inter-professional education – i.e. the bringing together of medical, nursing, counseling, and social work students – it promotes a collaborative understanding of best practices for spiritually integrated care (Puchalski et al., 2014). By embedding these pedagogical techniques into core training, academic institutions can equip graduates with the competencies needed to build rapport, enhance communication, and deliver culturally and spiritually responsive care in increasingly diverse healthcare environments.

Conclusion

Spirituality, faith practices, and religion remain deeply intertwined with the physical, psychological and social dimensions of health. The evidence consistently demonstrates that these dimensions influence not only disease progression and recovery but also health behaviors, coping strategies, and decision-making. When clinicians recognize the distinct yet overlapping roles of spirituality, faith practices, and religion, they are better positioned to deliver holistic care that honors the patient's values and lived experiences. Neglecting these factors risks overlooking powerful determinants of well-being, while intentional integration into care has the potential to improve treatment engagement, adherence, and quality of life.

To meet this need, health care professionals must possess both the ethical awareness and the practical competencies required to navigate spiritual and religious concerns effectively. Building these skills depends on comprehensive training approaches that integrate cultural competence, ethical decision-making, and clinical supervision into core curricula for medical and mental health education. This process involves not only expanding knowledge but also fostering reflective self-awareness and the ability to communicate across diverse worldviews. When such training is prioritized, clinicians are equipped to approach patients with empathy, respect, and cultural humility – and these are qualities that strengthen rapport, enhance communication, and ultimately contribute to better health outcomes.

In an increasingly pluralistic society, the integration of spirituality, faith practices, and religion into health care represents more than a professional courtesy; rather, it is an ethical and clinical imperative. By embedding these competencies into medical and mental health training, the profession moves closer to realizing genuine patient-centered care – i.e. care that engages the whole person, honors the

richness of their identity, and promotes healing in body, mind, and spirit. The challenge is clear, but so too is the opportunity: to prepare a generation of practitioners capable of providing healthcare that is both professional and compassionate.

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