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Lycett, D., Garvey, S. & Patel, R.

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A survey regarding the role of UK dietitians in spiritual care

Deborah Lycett[1] | **Stephen Garvey**[1,2] | **Riya Patel**[1]

[1]Institute for Health and Well-being, Coventry University, Coventry, UK

[2]School of Health, Sport and Food, University College Birmingham, Birmingham, UK

Correspondence

Deborah Lycett, Institute for Health and Well-being, Coventry University, Coventry CV1 5FB. UK.
Email: deborah.lycett@coventry.ac.uk

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Abstract

Background: Users of dietetic services have unmet spiritual needs, although no study has yet explored dietitians' opinion, perceptions or experience of assessing spiritual needs and delivering spiritual care in clinical practice.

Methods: A cross-sectional survey assessed the role of UK dietitians in spiritual care.

Results: Thirty-seven practicing dietitians, with experience ranging from newly qualified to over 21 years of practice, took part in the survey containing open and closed questions. Almost half (49%) of dietitians said they always conducted spiritual assessments and most (57%) said they sometimes made a referral for spiritual concerns. When spiritual issues arose, dietitians were highly likely to listen well (score 4.6 out of 5) and encourage service users in their own (the service user) spiritual or religious practices (score 4 out of 5). However, the likelihood of taking the initiative and enquiring about religious and spiritual issues was lower (score <3 out of 5) in all areas of practice including end of life care. This may have been because confidence around spiritual care was also low (score 4.7 out of 10), uncertainty was high (score >3.5 out of 5) and there was a strong desire to receive training (>4 out of 5). Qualitative responses expanded further on these results suggesting that there was positive "intention" to provide spiritual care, but lack of training was a significant barrier (qualitative theme: "inadequacies"). The recognition of necessity but uncertainty of how to meet spiritual needs was also shown through qualitative findings to be a source of "emotional labour", particularly where there were conflicting beliefs between a dietitian and service user.

Conclusions: Although limited by a small sample size, these results provide new knowledge that spiritual care is considered an important part of the dietitians' role and that this is the case regardless of the dietitians own spiritual identity or religion. Dietitians would value training in spiritual care so that they can support service user needs more readily and confidently.

KEYWORDS

dietetics, dietetic practice, mixed-methods, spiritual care

Key points

- Dietitians consider spiritual care to be an important part of their role, irrespective of whether they are spiritual or religious themselves.
- Dietitians listen well and encourage service users in their own (service user) spiritual or religious practices when spiritual concerns arise.
- Dietitians desire training to increase their confidence in providing effective spiritual care.

INTRODUCTION

Spiritual care is defined as care "… which recognises and responds to the needs of the human spirit when faced with life-changing events (such as birth, trauma, ill health, loss) or sadness, and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship and moves in whatever direction need requires".[1]

Systematic review evidence shows spiritual care improves quality of life and spiritual wellbeing in terminal illness[2] and spiritual needs span the life-course, even in "post-secular" societies.[3]

Healthcare chaplains are healthcare professionals who are the recognised *specialists* in spiritual care. In 2017, the Professional Standards Authority (PSA), the regulatory body for all registers of health and social care professionals, recognised the UK Board of Healthcare Chaplains (UKBHA) as an Accredited Register. However, there is growing recognition that *general* spiritual care should be provided by the wider healthcare team[4,5] and, although this is desired by service users, it is often lacking.[6]

Several health disciplines have explored the role of spiritual care within their professional groups. A landmark survey of 4054 nurses in the UK showed spiritual care is considered fundamental to good nursing practice but guidance and support was lacking.[7] Content analysis of free text responses from 2327 nurses found nurses had a broad, but inclusive understanding of spirituality considering this to be "universal", there was some uncertainty and fear surrounding the boundaries between personal belief and professional practice, and training was needed.[8] Although spiritual care has long been considered an important part of occupational therapy practice,[9,10] there is still a need for improvement in providing this aspect of care.[11] A survey of physiotherapists across Scotland showed the vast majority felt spiritual care was within their scope of their practice even if this was referring on to a more qualified professional such as a healthcare chaplain, but more training was needed.[12]

Dietitians are trained to consider the dietary needs of people from different faiths and cultures, to respect the needs of all service users, irrespective of personal beliefs and values, and ensure dietary advice is tailored to an individual's beliefs and preferences.[13] Their practice considers biopsychosocial aspects of health and must be evidence based.[13] However, the role of spiritual care within this context has not been explored, and no study has yet investigated dietitians' opinion, perceptions or experience of assessing spiritual needs more broadly and delivering spiritual care in clinical practice. Dietitians assess, diagnose and treat dietary and nutritional problems at an individual and wider public-health level. They are qualified and regulated healthcare professionals working in a variety of settings, as well as the National Health Service (NHS). They work as integral members of multidisciplinary, health professional teams to treat complex clinical conditions.[14] Dietitians come across many people who are struggling with a very wide variety of health problems, both physical and mental. They spend time with a service-user probing into diet, lifestyle and habits, gaining insight into a person's day-to-day living. During these conversations, emotional needs are often raised and dietitians listen compassionately, provide support within their sphere of competence, and refer on when necessary. However, spiritual needs, such as the need for meaning making and faith support, may be less apparent and go unaddressed. For example, someone may have existential questions and ask "why?" they have a particular diagnosis, or they may experience feelings of guilt, particularly where lifestyle has been a contributing factor, in disease development. Unresolved spiritual or religious concerns can lead to psychological distress,[15] which may in turn lead to loss of appetite in some; and overeating in others. Not only will such unresolved concerns delay coming to terms with a diagnosis, but also they may be a significant limiting factor in the effective self-management[16] that a dietitian is primarily trying to enable.

A systematic review has shown evidence of unmet spiritual needs among dietetic service users, particularly those living with cancer, chronic obstructive pulmonary disease, heart failure and diabetes.[15] These needs were present among patients from a variety of ethnicities and religions, as well as among those who were not religious. However, the dietitian's role in spiritual care has only been found in guidelines regarding nutrition and hydration at the end of life.[17]

The present study investigated, for the first time, dietitians' views on spiritual care, including how it related to their current practice, perceived future practice and potential training needs. The aim was to understand the views of dietitians from the UK regarding their role in assessing spiritual needs and delivering spiritual care in current and perceived future practice.

There were two study objectives. The first was to conduct a cross-sectional survey of UK dietitians' views on spiritual care in with respect to their current dietetic practice; perceived future practice; confidence in assessing spiritual needs and delivering spiritual care; and barriers to assessing spiritual need and delivering spiritual care and training needs. The scond was to explore whether dietitians who consider themselves as religious or spiritual are more likely to engage in spiritual care than those who do not.

METHODS

Study design

A cross-sectional survey was conducted with quantitative responses and the opportunity for open text comment.

Survey design

Survey instructions contained definitions of ambiguous terms, so that the meaning was clear and consistent for all respondents. Definitions were provided for religion,[18] spirituality,[19] religious and non-religious spirituality,[20,21] spiritual care,[4,22] spiritual struggles,[23] spiritual needs,[24] spiritual assessment[25] and competence/competency.[26,27]

The survey was based on previous questionnaires undertaken in other health professions. These were drawn from work undertaken in occupational therapy,[9,10,28] physiotherapy,[12] general practice,[29] nursing and midwifery[30,31] and physicians,[32] and adapted to be relevant to the dietetic profession; for example, referring to dietitians and specific areas of dietetic practice such as assessment of diet history and the meeting of nutrition and hydration needs.

The survey was divided into several sections; these are listed below with some examples of questions stated. Demographics, Current Employment, Experience and Specialist Area of Dietetics; Personal Spirituality or Religion; and Understanding of Evidence Around Religion, Spirituality and Health. An example question for this section was:

> Please tell us how much you agree with the following statements by selecting one of the five choices (ranging from strongly disagree to strongly agree): There is scientific evidence to underpin the association of religion and spiritualty in physical health

An example of a question from the section Current Practice and Barriers to Practicing Spiritual Care was:

> If religious or spiritual issues come up in discussion with service users, how often do you respond in the following way? Please choose one option for each statement (ranging from never to always): I encourage service users in their own religious/spiritual beliefs and practices

There were sections on Confidence in Spiritual Care and Current Practice; Relevance of Spiritual Competencies from Other Disciplines; Education on Spiritual Care Received; Training Needs and Future Practice; and Perceptions of the Role of the Dietitian in Spiritual Care. An example of a question in this section was:

> Considering the changing role of the profession of dietetics and the changing demographics and expectations of service users, please respond to the following (responses range from strongly disagree to strongly agree): I do not feel that spiritual care is part of the dietitian's role.

A copy of the survey is available as Supporting information (Doc. S1).

Ethical approval

Ethical approval (approval number P45108) was granted by Coventry University ethics committee prior to any data collection. The participant information sheet and consent form stated that participants had the right to withdraw from the study without consequence and that responses were confidential.

Pilot

The questionnaire was piloted with 10 dietitians and minor amendments were made to improve face validity and acceptability.

Participants

To take part respondents had to be registered dietitians. Student dietitians and related professions, for example, dietetic assistants were excluded.

Recruitment

The survey was accessible via a secure link on Online Surveys (https://www.onlinesurveys.ac.uk). Eighteen specialist groups of the British Dietetic Association (BDA) were invited to send this link to all their members. In this way, dietitians were recruited from a variety of settings and specialisms. There are currently just under 10,000 registered dietitians in the UK[33] of whom 8400 are full members of the BDA.[34] Participants were also recruited using professional networks including social media groups and discussion forums, namely Linkedin, Twitter, Facebook and Instagram, and the study was advertised in the BDA newsletters. The survey was open for 6 weeks from 10 April 2020, and reminders were sent out after the third week and at the beginning of week 6.

Sample size

A large, representative sample would have been ideal so that the results could be generalisable. However the feasibility of recruiting a large number was unknown given that this was the first attempt to engage dietitians in a conversation around spiritual care. Therefore, a specific sample size was not set. Thirty-seven dietitians were recruited.

Statistical analysis

Data were analysed using SPSS, version29 (IBM Corp.) and results displayed using descriptive statistics (mean [SD], percentage frequency). Responses with a choice of five or more ranked answers were treated as continuous variables. Independent *t* tests were used to investigate whether there was an association between a dietitian's own religiosity/spirituality and their level of agreement with engaging in spiritual care. A comparison on 37 responses between those who considered themselves religious or not, as well as those who considered themselves spiritual or not, was made. Following adjustment of the significance level using the Bonferroni calculation (α/n) for multiple testing $p < 0.01$ was considered statistically significant.

Qualitative analysis

Free text data captured in the open comments section were analysed thematically[35,36] using inductive, open coding that was both latent and semantic. Text was read and re-read, and line-by-line coding was completed. The coding process progressed by moving back and forth across the dataset in an iterative process where comparisons were made between codes. Those with similar meaning were grouped to form subthemes and themes. Reflexivity was considered, with codes and themes developed through the viewpoint of a dietitian who considers spirituality important on a professional and personal level. Codes and themes were peer reviewed with co-researchers to confirm interpretation and enhance credibility. The thematic narrative was written with comparison to the quantitative results to add depth of understanding to these.

RESULTS

Participant characteristics

Thirty-seven practicing dietitians, with wide ranging years of experience, took part in the survey. Most were female, white and working in the NHS at bands 6–8. Many specialist areas of interest were represented with the most common being gastroenterology. A similar number of dietitans were religious compared to those who were not (Table 1).

TABLE 1 Participant characteristics ($n = 37$).

Characteristic	Category	Frequency (%)
Demographic		
Gender	Male	4 (11%)
	Female	33 (89%)
Ethnic group	White British	23 (62%)
	White Irish	6 (16%)
	White – other	1 (3%)
	Indian	3 (8%)
	Pakistani	1 (3%)
	Asian – other	1 (3%)
	Black-African	1 (3%)
	Arab	1 (3%)
Highest educational qualification	Degree or equivalent	20 (54%)
	Masters	15 (41%)
	PhD	2 (5%)
Professional		
Pay band	5 or equivalent	10 (27%)
	6 or equivalent	13 (35%)
	7 or equivalent	8 (22%)
	8 or equivalent	4 (11%)
	Working in industry	1 (3%)
	Working in academia	1 (3%)
Years of experience as a dietitian	0–2	13 (35%)
	3–5	3 (8%)
	6–10	7 (19%)
	11–20	9 (24%)
	21+	5 (14%)
Specialist area of interest (more than one choice permitted)	Cardiovascular	3 (8%)
	Critical care	6 (16%)
	Diabetes	6 (16%)
	Food allergy	3 (8%)
	Food services	2 (5%)
	Freelance	1 (3%)
	HIV care	1 (3%)
	Gastroenterology	11 (30%)
	Generalist	2 (5%)
	Maternal and women's health	1 (3%)
	Mental health	5 (14%)

Professional knowledge of religion and spirituality

This was scored on a scale of 1–5 with 1 representing no agreement and 5 complete agreement. There was a consistent response, showing some agreement (mean

TABLE 1 (Continued)

Characteristic	Category	Frequency (%)
	Neurosciences	3 (8%)
	Obesity	8 (22%)
	Older people	7 (19%)
	Oncology	8 (22%)
	Paediatric	4 (11%)
	Parenteral and enteral nutrition	7 (19%)
	Palliative care	1 (3%)
	Public health	9 (24%)
	Renal	2 (5%)
	Respiratory	2 (5%)
	Sports	1 (3%)
Current place of work	NHS	29 (78%)
	Academia	1 (3%)
	Charity	3 (8%)
	Local authority	2 (5%)
	Private practice	3 (8%)
	Industry	1 (3%)
	Public health	1 (3%)
	Rehabilitation unit	2 (5%)
	Research	1 (3%)
	Professional body	1 (3%)
Personal religion and spirituality		
Religious	No	17 (46%)
	Yes	20 (54%)
Religious affiliation ($n = 20$)	Protestant Christianity	13 (65%)
	Catholic Christianity	2 (10%)
	Islam	2 (10%)
	Hinduism	3 (15%)
Spiritual	No	14 (38%)
	Yes	23 (62%)
Definition of spirituality	Religious	13 (57%)
	Non-religious	9 (39%)
	Religious and non-religious	1 (4%)
Religion/spirituality is a source of	Comfort	23 (62%)
	Stress	2 (5%)
	Not applicable	12 (32%)
Member of a religious/spiritual community	No	19 (51%)
	Yes	18 (49%)
Supportiveness of religious/spiritual community?	A little	8 (44%)
	A lot	10 (56%)
Intrinsic value of religion/spirituality		**Mean (SD)**
Extent to which religion and spirituality helps with coping (scale 1–10[a])		6.2 (3.3)
Importance of religion/spirituality (scale 1–5[a])		3.9 (1.2)
Amount religion helps with daily work responsibilities (scale 1–5[a])		3.5 (1.3)

[a]Higher value on scale donates a more positive response.

TABLE 2 Professional knowledge of religion and spirituality.

Evidence statement of association between R/S and health	Score, mean (SD)
Agreement level that there is evidence of an association of R/S in physical health (scale 1–5)	3.5 (0.9)
Agreement level that there is evidence of an association of R/S in mental health and well-being (scale 1–5)	4.0 (0.7)
Agreement level that there is evidence of an association of R/S in food choice (scale 1–5)	3.9 (0.8)
Agreement level that there is evidence of an association of R/S in changing eating behaviour (scale 1–5)	3.6 (0.8)

Abbreviation: R/S, religion/spirituality.

range 3.5–4 (scale 1–5)) that there is scientific evidence for the role of religion and spirituality in physical and mental health, as well as food choice and eating behaviour (Table 2).

Current Practice and confidence

Confidence in providing spiritual care in dietetics was low (mean score 4.7 out of 10); for the majority of dietitians, referral for spiritual care was made 'sometimes' and assessments regarding spiritual issues were made 'sometimes' to 'always'. The likelihood of enquiring about religious and spiritual issues was low (mean scores ranged from 2.5 to 2.8 out of 5, 1 being very unlikely and 5 very likely) in all areas of practice, including end of life care (Table 3).

TABLE 3 Current Practice and confidence.

Areas of practice in spiritual care		Score: mean (SD)
Confidence in providing spiritual care within dietetic practice (scale 1–10)		4.7 (2.4)
I refer to other professionals or spiritual leaders, whenever spiritual concerns and needs of a service user arises (%)	Never	19
	Sometimes	57
	Always	13
	N/A	11
I consistently use assessments which address spiritual needs (%)	Never	3
	Sometimes	43
	Always	49
	N/A	5
Likelihood of enquiring about spiritual and religious issues when (scale 1–5)		
Undertaking initial consultation		2.5 (1.0)
Taking a diet history		2.8 (1.0) (N/A = 1)
Discussing a course of treatment		2.6 (1.1)
Discussing artificial nutrition and hydration		2.6 (1.1) (N/A = 3)
End of life		2.8 (1.1) (N/A = 8)

Note: N/A was a selected response and refers to the question not being applicable to the dietetic practice of the self-reporting dietitian.

TABLE 4 Dietitians' response when spiritual and religious issues arise.

Response when spiritual and religious issues arise (scale 1–5)	Likelihood score: mean (SD)
Listen carefully and empathetically	4.6 (0.6)
Encourage service users in their own religious/spiritual practices	4.0 (0.9)
Uncertain how to identify those who want to discuss this	3.7 (1.0)
Uncertain how to deal with it	3.5 (0.9)
Feel lack of time	3.4 (1.1)
Find it difficult to use appropriately understood language	3.2 (1.0)
Feel concerned it will affect relationship with service user	3.1 (1.0)
Worry about negative attitude of my peers	2.9 (1.1)
Feel they are lower priority than dietary issues	2.7 (1.0)
Fear being disciplined or "struck off"	2.7 (1.2)
Concerned will project own beliefs	2.7 (1.3)
Feel discomfort	2.6 (0.9)
Feel not appropriate to my role	2.5 (1.0)
Tactfully change subject	2.1 (1.0)
Respectfully share own religious/ spiritual practices or experiences	2.0 (1.0)

Dietitians' response when spiritual and religious issues arise

This was scored on a scale of 1–5, with 1 being very unlikely and 5 very likely, and these are listed in descending order of likelihood in Table 4. The most common response when religious or spiritual issues arise was for dietitians to listen well and encourage service users in their own (the service user) spiritual or religious practices. The least common responses were that dietitians would discuss their own religious or spiritual practices or tactfully change the subject. The most common barriers (mean scores > 3) were that dietitians found it difficult to identify those who wanted to discuss religious or spiritual issues, they were uncertain how to deal with it, there was lack of time, they felt they didn't know what the most appropriate language was to use and they felt concerned talking about these things would affect their relationship with the service user. Although not common, the following responses were still relevant (mean scores ≤ 2.8): dietitians found discussions uncomfortable, felt they are lower priority than dietary issues, felt they were not appropriate to their role and were concerned they would be disciplined or 'struck off' as well as concerned they would project their own beliefs onto service users (Table 4).

Relevance of generic spiritual competencies

This was scored out of 5, with 1 indicating no relevance and 5 indicating high relevance. Generic spiritual competencies identified from the nursing profession were considered relevant often, in particular, considering ethical and confidentiality issues, communicating well, shared decision making, maintaining trusting relationships and providing holistic care (mean scores > 3.5). Assessing spiritual needs (mean 2.1) and searching for meaning in illness (mean 2.8) were considered less relevant (Table 5).

Training needs and future practice

Results were scored out of 5, with 1 indicating no agreement and 5 indicating total agreement. There was a high level of agreement (mean scores > 4) that dietitians

TABLE 5 Relevance of generic spiritual competencies.

Relevance of following competencies to dietetic practice (scale 1–5)	Score: mean (SD)
Consideration of ethical issues and confidentiality	4.6 (0.6)
Shared decision making	4.4 (0.8)
Maintaining trustful relationships	4.4 (0.7)
Communication	4.5 (0.6)
Delivery of holistic care	4.1 (0.7)
Implementing plans to meet spiritual needs	3.7 (1.3)
Review of outcomes and amendment of these plans	3.6 (1.3)
Planning for needs to be met	3.5 (1.3)
Facilitating acceptance of illness	3.3 (1.0)
Searching for meaning of illness	2.8 (1.0)
Assessing spiritual needs	2.1 (1.0)

would be: open to discussing spiritual needs; with the right training they would feel confident to do this: they would like to receive training; the most popular potential format for training was online activities and case scenarios. Dietitians did not feel they were adequately trained currently, nor that spiritual care was not part of a dietitian's role (mean scores ≤ 2.5) (Table 6).

Thematic analysis of free text comments

Nineteen dietitians provided additional comments. Codes developing out of free text comments identified three themes (Table 7) These are discussed below and illustrated with quotes from respondents (R) who were numbered 1 to 19.

Inadequacies

The theme "Inadequacies" was confirmatory of survey responses highlighting that time and training were barriers to the implementation of spiritual care in dietetic practice. For example:

> … but is hard to address particularly in an acute setting because of lack of training, competence and time (R2)

The interplay of Current Practice and Intentions

This theme contained two subthemes which provided an integrated understanding of "Current Practice" and "Intentions". These themes not only were in keeping with survey responses, but also shed light on the reasons behind responses. Quantitative data showed the likelihood of enquiring about religious and spiritual issues was low. Additional reasons for this were identified from the free

TABLE 6 Training needs and future practice.

Level of agreement (scale 1–5)	Score: mean (SD)
With the right training would feel confident to discuss spiritual concerns	4.3 (0.6)
Would like more education/training in this	4.1 (0.8)
Would be open to discussing spiritual needs	4.1 (0.7)
'On the job' training prepared me to deal with spiritual needs	2.5 (1.1)
Do not feel spiritual care is part of dietitian's role	2.2 (1.0)
Academic training prepared me to deal with spiritual needs	1.9 (0.8)
Training resources requested (rank order)	Online activities Case scenarios Printed resources Shadowing Group work Role play Competency assessment Supervision

TABLE 7 Thematic analysis of free text comments.

Codes	Subthemes	Themes
Insufficient training		Inadequacies
Insufficient time		
Already happening	Current Practice	The interplay of Current Practice and Intentions
Sometimes relevant, some of the time		
When patient raises it/ Important to them		
Identify, but not treat?		
Religious food practices		
Supportive	Intentions	
Could help or hinder behaviour		
Integrated care		
"elephant in the room"		Emotional labour
Taboo subject for dietitians		
Hard when feel beliefs could be harmful		

text. From the theme "Intentions", it did not appear to be because there was a lack of willingness or intention:

> I think many dietitians will support patients spiritual care as part of the overall empathetic, holistic approach to supporting patients (R1)

There was also recognition of the importance of spiritual care as part of integrated care:

> With the increasing need for integrated services, approaches and care of the service users, dietitians need to be more equipped with knowledge, tools and skills to address this subject (R14)

Also, as part of behaviour change support:

> … explore whether a service users religious or spiritual beliefs would help/be a barrier for them when trying to adopt healthier diets and lifestyles (R11)

The "Current Practice" theme revealed that dietitians felt that this issue was only relevant sometimes, and some of the time:

> … it is important for some service users, in some situations. This may be when patients are seriously ill or facing a chronic diagnosis (R4)

Discussions happened when the service user brought spirituality up themselves:

> … it seems that we would only discuss spirituality if the service user brings this up themselves (R7)

There was also a sense that these discussions were already happening in an informal way, and were perhaps not recognised for what they were:

> I do not assess it formally, but it often comes up organically. I think it is more so on patients minds in this context (oncology) (R5)

> I feel dietitians often assess these aspects without recognising them as spiritual care/assessment. When assessing a patient's mental health/feelings about their current situation, I think this involves their spiritual care as well (R2)

Survey responses showed mixed results regarding spiritual assessment, the relevance of spiritual assessment competencies to dietetic practice scored low (Table 5), whereas the likelihood of assessing spiritual needs scored highly (Table 2). This maybe, as discussed above, because assessment already occurs informally and organically. A noteworthy aspect with regards to spiritual assessment arose in the "Current Practice" theme, which showed that, for some, identification of the need for spiritual care was more in keeping with the role of the dietitian, than the delivery of spiritual care itself:

> I believe it is important to understand if a person had spiritual needs but I do not see that it is the role of the dietitian to offer spiritual input (R3)

For others, they felt:

> It doesn't just have to be the chaplaincy team (R15)

This is helpful in understanding the survey response regarding referral to others for spiritual care, which most often occurred "sometimes", but there were some (19%) that "never" did this and other dietitians (14%) that "always" did this.

Free text responses under the theme of "Current Practice" showed that understanding the religious dietary practices of a service user was clearly within the remit of dietetic practice:

> I would say the main religious concern I would address would be in relation to food preferences e.g., need for Kosher, Halal food and whether supplement drinks were suitable for some religious groups … (R9)

Emotional labour

Another theme arising from free text comments was that of "Emotional labour"; the concept of healthcare professionals suppressing their own emotions to portray a suitable work-related emotion. This was a result of dietitians feeling there was an issue which should be discussed with service users, but not feeling equipped to do so, it became the "elephant in the room" in consultations. It was also seen as a taboo subject for discussion with other dietitians.

> … We don't seem to talk about this at all and if anything, we seem to steer away from it … (R7)

It could also be a source of inner conflict particularly if a dietitian felt that a belief held by a service user could be potentially harmful:

> I think it is very difficult when you do not agree with the person's belief e.g., that God will cure them of HIV etc and can see potential for harm (R12)

Comparison of responses between religious/spiritual and non-religious/spiritual dietitians

There was no significant difference in response to survey questions based on whether a dietitian was either religious or not, or spiritual or not (analysis in the Supporting information: Doc. S2, Tables S1–S4). Thematic analysis of free text comments was consistent with this as demonstrated by the following quote:

> Although I do not draw upon spirituality and religion in my life it is easy to recognise that others do. In acknowledging a part of a person's life that is important to them we provide better care (R15)

DISCUSSION

Overall, the survey results showed recognition of the role of religion and spirituality in dietetic care. Dietitians felt that spiritual care was an important part of their role, ranging from assessment of spiritual needs to delivery of spiritual care itself. Most commonly, consideration of spiritual needs was regarded as appropriate in some situations, some of the time, rather than needed in all situations. This was also reflected in the qualitative subtheme around Current Practice. Dietitians were likely to listen well and encourage service users in their own (the service user) spiritual or religious practices when spiritual issues arose. However, the likelihood of taking the initiative and enquiring about religious and spiritual issues was low in all areas of practice including end of life care. This may have been because confidence around spiritual care was also low, uncertainty was high and there was a strong desire to receive training. Qualitative responses expanded further on these results suggesting that there was positive "intention" to provide spiritual care, but lack of training was a significant barrier (qualitative theme: "Inadequacies"). The recognition of necessity but uncertainty of how to meet spiritual needs was also shown through qualitative findings to be a source of "Emotional labour", particularly where there were conflicting beliefs between a dietitian and service user.

These findings are highly consistent with those seen across other healthcare professions, including surveys and qualitative studies, in nursing,[7,8,37] palliative care medicine,[38] physiotherapy,[12] occupational therapy[11] and, most recently, pharmacy.[39] A common thread remains across the present study and the findings across the wider literature around healthcare professionals views of spiritual care, which is that spiritual care is considered as fundamental to incorporate into practice, although better training and education on its provision is required for it to be practiced more widely and with confidence.

The present study supports the growing narrative that "spirituality is everybody's business"[40] and the recognition that, although healthcare chaplains are specialists in spiritual care, other healthcare practitioners are "non-specialists" within this field, requiring a general level of competency in spiritual care.[4]

The European Enhancing nurses' and midwives' competence in Providing spiritual care through Innovative education and Compassionate Care (EPICC) project ran a mixed methods Delphi study and successfully developed the EPICC Spiritual Care Education Standard. This standard describes the spiritual care competencies expected from undergraduate nursing and midwifery students, in particular. For every competence, the learning outcomes are described in aspects of knowledge, skills and attitudes. It should be considered that these competencies are practiced within a compassionate relationship and founded in a person-centred and reflective attitude of openness, presence and trust, which is fundamental for nursing and midwifery as a whole. Although primarily focused on nursing and midwifery, it is considered a starting point for discussing spiritual care competences in other healthcare professions.[1]

Our survey of dietitians showed that the generic spiritual competencies previously identified from the nursing profession[41] were often considered relevant in dietetic practice. Particularly, ethical and confidentiality issues, communicating well, shared decision making, maintaining trusting relationships, and providing holistic care. Assessing spiritual needs and searching for meaning in illness were considered less relevant. Therefore, these areas may require further exploration and enhanced education when tailoring training to dietitians. Preferences for training delivery were online and case scenarios.

Responses did not differ according to religiosity. However, there was insufficient power in the sample size to avoid a type II error (false negative). Nonetheless, the qualitative results echoed that those who were non-religious/spiritual considered spiritual care important. Few studies have directly compared religiosity with the provision of spiritual care and have found mixed results, a cross-sectional study on 350 American nurses found nurse religiosity, particularly prayer frequency, was weakly associated with frequency of spiritual care. However, such care was infrequent even amongst a predominantly religious sample.[42] Qualitative studies in nurses[8] and palliative care doctors[43] show that their own religion or spirituality may in fact present a barrier to discussing spirituality for fear of saying the wrong thing. However, when asking this directly, in our more recent survey of dietitians, this was not found to be a common concern.

TABLE 8 Domains of the Curriculum Framework for the preregistration education and training of dietitians to which spiritual care can be mapped.

Domain	Category	Content
Dietetic knowledge	K5: Social, Educational and Psychological Theory *Critical, integrated and applied knowledge and understanding of sociology and psychology including social, communication, educational and qualitative research theories*	(f): social theory in relation to: – human behaviour around food choice, health, illness – health behaviour, behaviour change; – service user-professional relationships and the influence of power (h): the psychological dimensions: – of normal and disordered eating, hunger, satiety and food choice; – of the psychological background to health behaviour; – of long-term health conditions
	K6: Public Health *Broad knowledge and understanding of the role of dietetics in public health and public health nutrition*	(c): how social organisation including inclusion, exclusion, health inequalities, social injustice, social inequality and different cultural belief systems impact on health and disease
	K8: Research and Information Management *Critical and applied knowledge and understanding of research and information management*	(f): the principles of scientific enquiry, evidence informed practice, critical appraisal of the literature, audit and evaluation of practice
Dietetic skills	S2: Applying Nutrition and Dietetic Process Ability to demonstrate critical, integrated and applied knowledge, understanding and application of the model and process	(c): understand the rationale for and gather appropriate sources of information regarding medical, social, psychological, personal, cultural and economic factors (e): demonstrate sensitivity to social, economic and cultural factors that may affect the interaction between the dietitian and service user (dd): understand and apply knowledge of sociology and psychology to support and motivate individuals to change their dietary intake and food habits (ee): identify external resources, as appropriate, in order to support the client's dietetic needs and care plan
	S5: Research *Ability to demonstrate critical, integrated and applied understanding and application of the theories, concepts and principles of research and evidence informed practice*	(j): use nutrition and dietetic research findings to support evidence-based practice in dietetics
Dietetic values and behaviours	V1: Professionalism *Ability to demonstrate a critical, integrated and applied understanding of professionalism*	(q): deliver values based care; acting with integrity, self-management and self-awareness; take an objective approach to meeting service user needs at all times, irrespective of personal beliefs and values

Open text responses showed a qualitative theme of emotional labour, particularly when there was potential conflict between beliefs and treatment. This is similar to findings amongst oncology doctors[43] and is also consistent with findings of the lived experience of dietitians involved in decisions around artificial nutrition and hydration.[44] Support to deal with this and consideration of the well-being of dietitians may also need to be addressed considering the negative psychological impact of emotional labour in healthcare professions.[45] There is a need to build resilience[46] and systematic review evidence shows creating a workplace (in healthcare, but also more broadly) that supports the expression of religious identity at the same time as maintaining a broader climate of inclusion is associated with improved well-being of staff and service users, as well as improved work-related outcomes.[47] This is something to be considered by managers.

Strengths and limitations of the study

Spiritual care has been widely investigated among nursing and medical doctors, although this is the first study to investigate how dietitians view this as part of their practice.

The survey reduced the ambiguity found in similar surveys in their professions by clearly defining ambiguous terms at the beginning. Face validity and acceptability was also improved through an initial pilot test.

The present study is limited by the small number of participants, and there was insufficient power to be certain that these views can be generalised to the UK whole profession and much less globally. The sample may contain self-selection bias, with only those interested in the topic taking part. Our sample was predominantly white and female, with similar numbers of religious and non-religious individuals, and this is proportionally similar to the national register of dietitians.[48] However, the small sample did allow for a more in-depth understanding of the quantitative results through the thematic analysis of open text responses.

Implications for future research and practice

Only views of dietitians were captured in the present study and there is a lack of the service user voice. Investigation of the views and experiences of spiritual care from users of dietetic services would be a valuable addition to this piece of work. Evidence from other health professions suggests that patients want their healthcare professionals to discuss and support their spirituality, and that this is not currently accomplished sufficiently. A systematic review identifying spiritual care in dietetic practice highlighted that dietetic patients did require this to be provided particularly at their appointments.[17]

The present study provides a clear indication that spiritual care is part of the role of dietitians, but specific training is required. We therefore recommend that the inclusion of spiritual care training is considered within continuing professional development and pre-registration curricula.

Spiritual care could be mapped onto several domains (Table 8) of the Curriculum Framework for the pre-registration education and training of dietitians. This includes Dietetic Knowledge of psychological theory, as well as public health inequalities. Dietetic Skills of: applying the Nutrition and Dietetic Process to spiritual care as previously described,[20] and Dietetic Skills of research, particularly using research findings to support evidence-based practice in dietetics. This, in combination with, using knowledge to critically appraise research, is a call to action regarding the evidence base of spiritual care in clinical practice, to which the present study contributes. Additionally, professionalism, in particular the delivery of values based care, meeting service user needs at all times, irrespective of personal beliefs and values, aligns to spiritual care.

These aspects of education and training in spiritual care for dietitians are in addition to the generic standards of proficiency for all healthcare professionals. Of utmost relevance is proficiency to: recognise the impact of culture, equality and diversity on practice and practise in a non-discriminatory and inclusive manner; to recognise limits of competency and know when to seek advice and refer on; and to recognise the power imbalance with being a healthcare professional and ensure this is not abused.[49]

The impact of incorporating spiritual care into dietetic training should be evaluated with respect to its influence on dietitians practice, confidence and emotional labour, as well as service user outcomes.

In the meantime, we recommend that dietitians access training resources in spiritual care from other professions such as nursing and midwifery, mental health[50] and interprofessional education.[51] We suggest that dietitians discuss with their local healthcare chaplaincy colleagues to see how best to ensure the spiritual needs of their service users are met within their current workplaces.

CONCLUSIONS

This is the first study to investigate dietitians' views on spiritual care. Although the sample size is limited, it provides new evidence that spiritual care is supported and valued amongst the dietetic profession, and also that training in spiritual care for dietetic practice is lacking.

AUTHOR CONTRIBUTIONS

Deborah Lycett and Stephen Garvey contributed to the conception and design, interpretation of the data, and drafting of the paper. Riya Patel contributed to the interpretation of the data and drafting of the paper. All authors have critically reviewed its content and have approved the final version of the manuscript submitted for publication.

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CONFLICTS OF INTEREST STATEMENT

The authors declare that there are no conflicts of interest.

DATA AVAILABILITY STATEMENT

This was not included in the consent form within the ethics application and so the data will not be publicly available.

ORCID

Deborah Lycett http://orcid.org/0000-0002-4525-6419

PEER REVIEW

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AUTHOR BIOGRAPHIES

Deborah Lycett is Director of Research in Health and Wellbeing at Coventry University. She is a professor and registered dietitian with a PhD in behavioural medicine, interested in religion/spirituality and dietetic practice.

Stephen Garvey is Deputy Dean (Teaching, Learning and Digital) within the School of Health, Sport and Food at University College Birmingham. He is a registered dietitian with an interest in person-centred care.

Riya Patel is a research fellow at Coventry University within the centre for healthcare and communities. She has a PhD and is a chartered psychologist and is interested in religion spirituality and health.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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