Embracing a Biopsychosocial-Spiritual Model of Care for Nutrition and Behaviour Change

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Programme of Research in Spiritual Care

- Attended ECRSH in Bern, in 2012
- Inspired and ‘called’ to change direction of my research
- Went back to UK and changed jobs
- Established this as a niche area of research
  - Grants
  - PhDs
  - Research staff
  - Health professionals trained
- Hosted ECRSH at Coventry University in 2018
- Consistent large funding hard to win
- Took on leadership and management roles
- Allowed me to continue in a smaller way, but fruitful none the less.

Why?

Nutritionally sound, psychologically informed interventions often fail to sustain change.

Poor outcomes, relapse, disengagement, and distress persist.

What role do meaning, identity, and spirituality play?

Research Programme of Spiritual Care in Nutrition and Dietetic Practice

Identified Unmet Need

Explored Current Practice

Intervention Development

Broader review of Interventions

Integrated new knowledge into clinical nutrition and dietetic practice

Identifying Unmet Need

Lycett, D., & Patel, R. (2023). **Spiritual Care within Dietetic Practice: A Systematic Literature Review.** Journal of Religion and Health, 62(2), 1223-1250. https://doi.org/10.1007/s10943-022-01555-z

Research question: Do dietetic service-users experience unmet spiritual or existential needs, and are these addressed?

Methods

- 1,433 records screened (MeSH and Keyword search for spiritual care and (nutrition or dietetic practice) in Medline, CINAHL, PsycINFO and AMED)
- 13 included studies
- Mixed quantitative and qualitative designs
- Narrative synthesis due to heterogeneity

Key Findings

- Medium quality evidence
- Unmet spiritual needs present in all included studies.
- In patients with cancer, diabetes, heart failure, and COPD.
- Present across religious and non-religious groups.
- Strong association with psychological distress.

Conclusion

- Professional Gap
- Dietitians involved almost exclusively in: end-of-life nutrition decisions
- No trials of spiritual care delivered by dietitians
- Spiritual determinants largely unaddressed in routine care
- Spirituality is not optional or peripheral
- It is a systematically neglected determinant of eating-related distress
- Provides the ethical and empirical justification for intervention

Current Practice

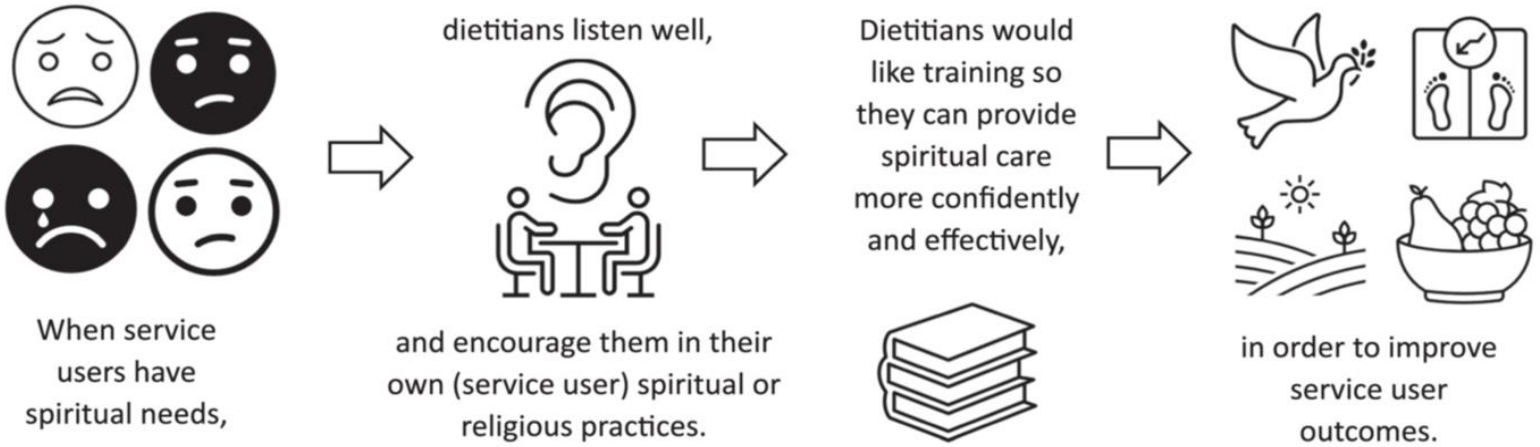
Lycett, D., Garvey, S., & Patel, R. (2024). **A survey regarding the role of UK dietitians in spiritual care**. Journal of Human Nutrition and Dietetics, 37(3), 749-761. https://doi.org/10.1111/jhn.13306

Research question: What is the current understanding and practice of UK Dietitians?

Methods

- Cross-sectional survey of **37 UK dietitians**
- Included open and closed questions
- Participants ranged from newly qualified to 21+ years' experience

Key Findings



Qualitative Themes

- Positive “intention” to provide spiritual care
- Major barrier: lack of training (“inadequacies”)
- “Emotional labour” particularly if held conflicting beliefs

Conclusion

- Dietitians view spiritual care as an important aspect of practice, regardless of their own religion/spirituality.
- Training is needed to improve confidence, reduce uncertainty, and better support patient spiritual needs.
- First study of kind but limited by small sample size

Intervention development

Lycett, D., Patel, R., Coufopoulos, A., & Turner, A. P. (2016). **Protocol of Taste and See: A Feasibility Study of a Church-Based, Healthy, Intuitive Eating Programme.** Religions, 7(4), Article 41. https://doi.org/10.3390/rel7040041

Patel, R., Lycett, D., Coufopoulos, A., & Turner, A. (2017). **A Feasibility Study of Taste & See:** A Church Based Programme to Develop a Healthy Relationship with Food. Religions, 8(2), Article 29. https://doi.org/10.3390/rel8020029

Patel, R., Lycett, D., Coufopoulos, A., & Turner, A. (2017). **Moving Forward in Their Journey: Participants' Experience of Taste & See,** A Church-Based Programme to Develop a Healthy Relationship with Food. Religions, 8(1), Article 14. https://doi.org/10.3390/rel8010014

Lycett, D. (2018). **Protocol for a cluster randomised controlled trial to compare the "taste & see" programme**—A church-based programme to develop a healthy relationship with food—With a wait-list control. Religions, 9(3), Article 88. https://doi.org/10.3390/rel9030088

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Taste & See: A church-based programme to develop a healthy relationship with food

- Four papers
- Sequential design: intervention development (protocol) → feasibility → embedded qualitative study → RCT protocol
- Mixed methods approach
- Community (church) setting

Intervention Components

- Intuitive eating principles vs dietary restriction
- Psychoeducation (nutrition and behaviour)
- Christian spiritual principles and reflection (optional)
- Group discussion and support
- In-person with paper copies or online


Exploring spiritual needs that can only be met by God
Christian principles of freedom...
Less emotional eating
Unconditional permission to eat
Give up eat more
Dietary Restriction
Guilt Shame
Difficult to sustain
Self-acceptance and body appreciation
Eating in response to physiological hunger
Love, forgiveness and acceptance by God
...with responsibility

Taste & See: Feasibility Study

- Single group pre–post study (n = 18)
- Recruited through church networks
- Non-clinical community sample
- 10 week intervention
- Intention-to-treat analysis with baseline observation carried forward

Church volunteers effectively trained

Participants recruited and retained

Collaborative working between university and faith-based community

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Change in outcomes at 3 months:

-19.4

Emotional eating

+6.7

Intuitive eating

-3

Depression

+0.6*

Mental Well-being

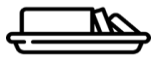
-4.1

Anxiety

+4.8

Spiritual Well-being

-7.3g/d



Dietary fat

+11.7

Quality of life

-1.6kg

Taste & See: Embedded Qualitative Study

- Semi-structured interviews were carried out after participants had completed the Taste & See programme.
- Interviews were transcribed and analysed using deductive thematic analysis.

‘God and food issues were separate at first’
‘Began to use faith as resource’
‘Eating freely was a challenge initially’
‘Empowerment and enjoyment in freedom’
‘Addressing more than just a weight problem’
‘Not always easy coping with other participants’

Cluster RCT

- Feasibility not efficacy
- Findings preliminary
- Small Sample
- No control group
- Cluster RCT with 2-year follow-up
- Results to be analysed

Review of Interventions

Not yet published (part of Ellen Bennett's PhD)

Research question: What is the difference in efficacy of religious and spiritual integrated interventions, compared to control interventions to improve outcomes in adults with obesity, eating disorders or disordered eating?

Systematic review and meta-analysis

- 8,483 unique records → 35 included randomised controlled trials
- Follow-up range: immediate post-intervention to 23 months
- Risk of bias:
  - Low risk: 16 studies
  - Medium risk: 15 studies
  - High risk: 4 studies

Intervention Conditions

Spiritual / Religious Components*

- Mindfulness-based practices (≈ 17 studies)
- Meditation (e.g. concentrative, healing, movement-based; ≈ 9 studies)
- Yoga (often framed implicitly spiritually; multiple studies)
- Compassion, non-judgement, acceptance, meaning-making
- Religious components (minority):
  - Scripture or religious texts
  - Prayer (personal or group)
  - Sermons or faith-leader involvement

*Mapped to RHIBS taxonomy: Patel, R., Jong, J., Worthington, E. L., & Lycett, D. (2022). The development of the **Religious Health Interventions in Behavioural Science (RHIBS) Taxonomy**: a scientific classification of religious practices in health. Translational behavioral medicine, 12(10), 987–1003. https://doi.org/10.1093/tbm/ibac054

Intervention Conditions

Behavioural /Lifestyle components

- Most spiritually integrated interventions also included conventional elements:
  - Healthy eating or nutrition education (≈ 13 studies)
  - Physical activity (≈ 22 studies; e.g. walking, yoga, stretching)
  - Psychological techniques in some trials:
    - CBT
    - Acceptance and Commitment Therapy
    - Motivational interviewing
    - Mindfulness-based stress reduction

Control Conditions

Control arms varied substantially across studies

Five main comparator categories identified:

1. **Usual Care / Standard Health Advice:**

   general nutrition advice; routine weight management; standard eating disorder care (most common)

2. **Non-Spiritual Behavioural:**

   nutrition education; physical activity; psychoeducation (matched contact without spiritual content)

3. **Active Psychological Controls:**

   CBT groups; emotional support groups (control for attention and group effects)

4. **Wait-List Controls:**

   Delayed intervention; used in pilot/feasibility studies

5. **Minimal Controls:**

   Single session or written advice only

Eating Behaviour Outcomes

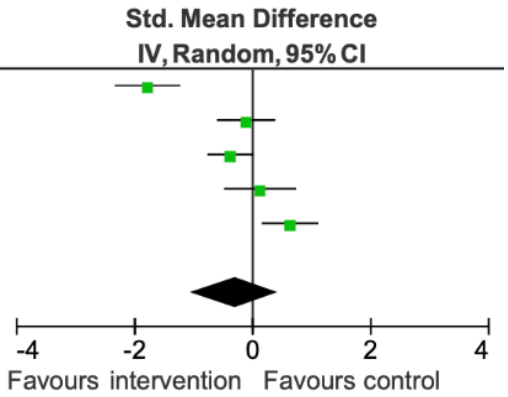
- 19/19 studies at <3 months showed positive change
- Reductions in **binge eating, emotional eating, hunger**
- Also reduced **restrictive episodes**
- Consistent across obesity, eating disorders, and subclinical samples

Eating Behaviour: Meta-analysis

Study or Subgroup	Intervention Mean	SD	Total	Control Mean	SD	Total	Weight	Std. Mean Difference IV, Random, 95% CI
McIver, et al. (2009)	14.5	6.8	37	27.2	7.3	34	19.7%	-1.78 [-2.34, -1.23]
Pacanowski, et al. (2020)	10.2	8.63	32	11.12	6.78	31	20.1%	-0.12 [-0.61, 0.38]
Salvo,. et al. (2022)	8.74	6.39	47	11.7	8.55	58	20.8%	-0.38 [-0.77, 0.00]
Ugarte et al. (2023)	14.14	7.6	20	13.21	7.16	21	19.2%	0.12 [-0.49, 0.74]
Zervos, et al. (2022)	15.06	6.55	47	10.67	7.44	28	20.2%	0.63 [0.15, 1.11]
Total (95% CI)			**183**			**172**	**100.0%**	**-0.30 [-1.04, 0.44]**

Heterogeneity: $Tau^2 = 0.64$; $Chi^2 = 44.41$, df = 4 ($P < 0.00001$); $I^2 = 91\%$

Test for overall effect: Z = 0.80 (P = 0.42)



- SMD: −0.30 (95% CI −1.04 to 0.44), p = 0.42
- But Heterogeneity: 91%
- Sensitivity (removing studies with high risk of bias): SMD −0.41 (95% CI −1.30 to 0.49) I^2 93%
- Interpretation: small–moderate effect, high variability in interventions, Cohen's d (magnitude of difference) was significant

Summary of Secondary Outcomes

Outcome	RCTs	Short-term (<3m)	Key Interpretation
Quality of Life	7	5/7 favoured intervention	Stronger effect >8 weeks
Body Perception	8	7/8 favoured intervention	Improved body appreciation Reduced thin-ideal internalisation Reduced body dissatisfaction
Anxiety	5	4/5 favoured intervention	Metanalysis showed moderate, **non significant**, effect; high heterogeneity
Depression	7	2/3 favoured intervention	Variable; better in longer/compassion-based interventions
Weight/BMI/Waist Circumference	6	All favoured intervention	Metanalyses showed small, **non significant** effects

NB meta-analysis containing between 100-160 participants

Qualitative Study of Eating disorder Intervention

Mitra, B., Archer, D., Hurst, J., & Lycett, D. (2023). **The Role of Religion, Spirituality and Social Media in the Journey of Eating Disorders: A Qualitative Exploration of Participants in the "TastelifeUK" Eating Disorder Recovery Programme**. Journal of religion and health, 62(6), 4451–4477. https://doi.org/10.1007/s10943-023-01861-0

Introduction

- Religion/spirituality can both **support** and **challenge** recovery
- Social media plays a complex role: **supportive communities vs harmful comparisons**
- Study focuses on participants in **TastelifeUK**, a charity run community-based recovery programme for patients and their carers (8 sessions)

Methods

Design: Qualitative study using semi-structured focus groups

Participants: 17 total (people living with EDs, carers, volunteers)

Mostly Christian; varied ED diagnoses

Setting: TastelifeUK (8-session community recovery course)

Data collection:

- 4 online focus groups (Microsoft Teams)
- Audio-recorded and transcribed

Analysis: Reflexive thematic analysis (Braun & Clarke)

Ethics: Approved by Coventry University Ethics Committee

Results

Five main themes identified, central importance of relationships (with God, people, communities, social media)

Theme	Subthemes
1. Relational support from God	a) Hope, help, meaning b) Spiritual struggle (guilt, unanswered prayer)
2. Relational support from people	a) Shared experiences reduce isolation b) Mixed groups (carers + patients) both challenging and beneficial
3. Church community	a) Compassionate, prayerful support b) Judgment, misunderstanding, avoidance
4. Widening community ("ripple effect")	a) Peer accountability beyond programme b) Desire to help others based on lived experience
5. Social media “should come with a health warning”	a) Online support and recovery communities b) Comparison, anxiety, pro-ED content c) Selective and limited use viewed as protective

Implications

- Religion/spirituality can act as a protective coping resource, but also a source of tension
- Its role in eating disorders (ED) recovery should be recognised and addressed
- Healthcare providers and faith communities need better ED awareness and training
- Social media benefits depend on content and use this should be addressed explicitly in recovery support
- Community-based programmes like TastelifeUK offer valuable supportive spaces

Integration into Professional Practice

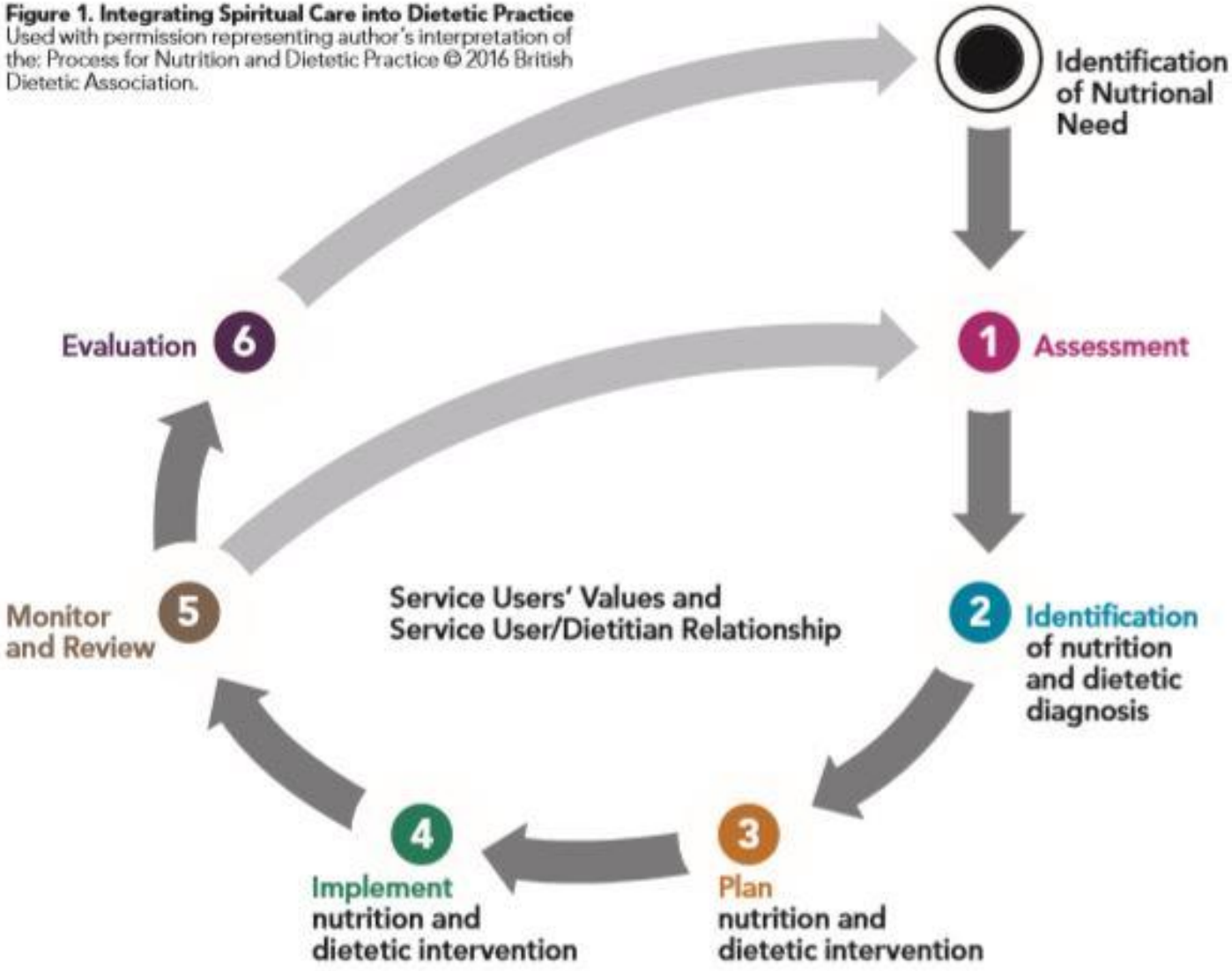
Lycett D. (2020) **Spiritual Care and Dietetic Practice – A call beyond cultural competency**. BDA Resource Library https://www.bda.uk.com/resource/spiritual-care-and-dietetic-practice-a-call-beyond-cultural-competency.html.

Bashir T, Price S, Parmar KK, and Lycett D (2026) Global dietary cultures (supporting individuals to make dietary changes within their food culture and identity) In **Manual of Dietetic Practice 7th edition** (pp. 130-145). Wiley

Translation into Professional Standards

- Values-based care, meeting service user needs at all times, irrespective of personal beliefs and values
- Recognise the impact of culture, equality and diversity on practice and practice in a non-discriminatory and inclusive manner
- Recognise limits of competency and know when to seek advice and refer on
- Recognise the power imbalance with being a healthcare professional and ensure this is not abused
- Patient first, enquiring of and working with their beliefs and practices.
- Dietitians need to be aware of their own assumptions and their own beliefs or religious or spiritual identity, so that there is neither coercion nor judgement on the part of the dietitian with respect to any spiritual or religious belief or practice.

Figure 1. Integrating Spiritual Care into Dietetic Practice
Used with permission representing author's interpretation of the: Process for Nutrition and Dietetic Practice © 2016 British Dietetic Association.



Assessment

"Enquiring whether a patient has religious or spiritual beliefs that might be helpful, or causing them concern, at the present time is neither threatening nor coercive"

- Ask simple, open questions to explore spirituality:
  - Do you consider yourself spiritual or religious?
  - Do your beliefs influence your eating or health behaviours?
  - Do you have any spiritual concerns at this time?

- Key points:
  - Questions can be direct or integrated into conversation
  - Spiritual concerns may emerge gradually
  - A "no" to being religious does not exclude spiritual needs

🔍 Identification

- Consider spirituality in the cause of the problem:
  - —Could spiritual concerns contribute to the nutrition issue?
  - —Are spiritual struggles influencing coping behaviours (e.g. binge eating)?
- Key Point:
  Recognising spirituality as a potential maintaining or contributing factor

Plan

- How:
  - Could a spiritual goal help?
- What:
  - What spiritual/religious support might this be?
- Who:
  - Does the patient want this?
  - Who might be able to provide it?
  - Consider chaplaincy, faith leaders, community, access to resources (programmes, books, media)
- Key Point:

  Chaplaincy provides pastoral care to all (not only end-of-life)

Implementation

- Refer to chaplaincy services where appropriate
- Engage with faith/community networks or leaders
- Conversations with trusted others
- Independent exploration (reading, faith websites, groups)
- Use of personal practices (e.g. prayer, scriptures)
- Participation in faith-based lifestyle programmes
- Maintain links with chaplaincy who can identify and verify services to refer to

Monitor and Review

- Monitor engagement with agreed spiritual goals
- Examples: attended chaplain; discussed issues with others
- Participation in programmes or spiritual practices
- Review and adjust goals based on changing needs

Evaluation

- Assess outcomes against goals

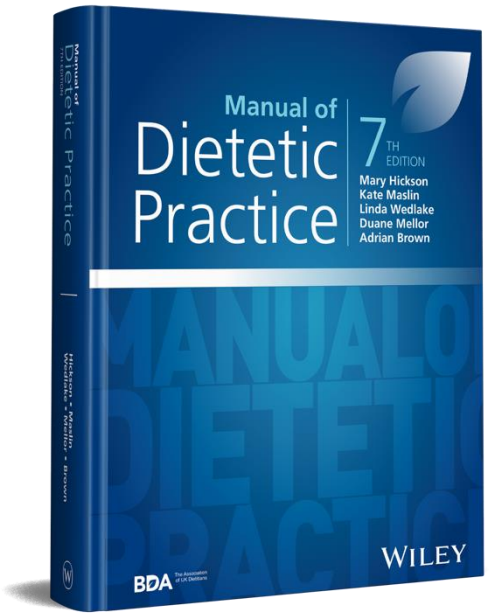
  (achieved/partial/not achieved)

- Key evaluation questions:
  - Do you have any religious beliefs that were not adequately considered by your treatment?
  - Have any spiritual worries or concerns you had about this been addressed?
  - Have you been able to take part in any spiritual or religious activities that have been important to you at this time?

Manual of Dietetic Practice (May 2026)

- The Manual of Dietetic Practice remains the definitive reference for dietitians at every stage of their career. Now in its 7th edition, this essential text has been extensively revised and expanded to reflect the latest developments in dietetic science, clinical practice, and public health nutrition.

- Incorporating the latest evidence and research in the field and endorsed by the British Dietetic Association, the Manual sets the gold standard in dietetic practice.



Key points

- Formal inclusion of spirituality and spiritual care:
  - Spirituality is a way to seek and express meaning and purpose. It may be religious or secular. Spiritual care recognises these needs and compassionately supports individuals to find meaning during difficult times.
  - Dietitians, are well-placed to identify spiritual or existential concerns that influence eating behaviours and health outcomes. Unmet spiritual needs are found among variety of dietetic service users.
  - Unresolved spiritual struggles (e.g. unhealthy sense of guilt) or negative religious coping (e.g. anger at God) can lead to psychological distress , maladaptive coping (e.g., overeating), and hinder self-management.
  - Positive spiritual support (e.g. belonging to a close community) or positive religious coping (e.g. prayer) provides a resource in times of difficulty that reduces stress.
  - Positive religious coping has been shown to help support dietary change, particularly for weight control and diabetes management especially among faith communities

Conclusion

- In practicing spiritual care dietitians should also recognise the evidence-based role that religion and spiritually plays in health.
- They should enquire whether a service user has religious or spiritual beliefs that might be helpful or causing them concern at the time and consider what support or signposting (e.g. chaplaincy) is needed to address any concerns or reinforce positive coping .
- In this way dietitians can provide holistic spiritual care that will improve nutrition and dietetic outcomes.

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