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ORIGINAL PAPER

Religious, Spiritual, and Cultural Influences of Dysphagia in the USA

Emily J. Helder[1] · **Elizabeth Oommen**[2] · **Natalie Bekmetjev**[1] · **Abigail Mosher**[1] · **Laura Schipper**[3] · **Stacia Hoeksema**[4] · **Katie Georges**[2] · **Maddie Willemstein**[2] · **Anna Bierma**[2] · **Emily Cameron**[2]

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Abstract

Dysphagia, difficulty with swallowing, affects approximately 16% of US adults and can result from conditions such as stroke, neurodegenerative conditions, and cancer. Despite growing emphasis on the intersection of religion/spirituality (R/S) and health, little research has examined these connections in dysphagia. This qualitative study explored the impact of dysphagia on engagement in R/S rituals and communities and access to cultural food traditions. It also examined ways that R/S beliefs shaped coping practices in persons with dysphagia and their caregivers. Data were gathered through focus group sessions as a part of an interprofessional support group. Participants' dysphagia symptoms were caused by a variety of conditions including cancer, Parkinson's disease, and cervical surgery. Thematic analysis revealed that dysphagia limited participants' ability to participate in religious rituals (e.g., communion), attend faith-based social events, and consume cultural foods. At the same time, themes from the focus groups highlighted the role of R/S in fostering resilience, gratitude, and meaning-making in the context of disability. R/S communities were also identified as crucial sources of support. Caregivers emphasized that their religious beliefs guided their caregiving roles and decisions. These findings underscore the need for holistic, person- and family-centered care that incorporates R/S assessment and intervention. This study contributes to the growing literature advocating for the integration of R/S dimensions into dysphagia, highlighting both challenges and opportunities for enhancing well-being in the face of chronic illness.

✉ Emily J. Helder
helder@hope.edu

[1] Psychology Department, Hope College, 35 E. 12th Street, Holland, MI 49422, USA

[2] Speech Pathology and Audiology Department, Calvin University, Grand Rapids, USA

[3] Nursing Department, Calvin University, Grand Rapids, USA

[4] Sociology and Social Work Department, Calvin University, Grand Rapids, USA

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Introduction

Religion is defined as a "system of beliefs and practices observed by a community, supported by rituals that acknowledge, worship, communicate with, or approach the Sacred, the Divine, God... or Ultimate Truth, Reality, or nirvana," while spirituality is defined as a "personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and formation of community" (Koenig, 2008, p. 11). There is growing interest in the ways that religion and spirituality (R/S) connect with health outcomes and how health providers could address R/S beliefs and practices with their patients (Puchalski, 2013). For example, R/S have been linked with recovery trajectories after illness or surgery, coping with illness and disability, and in developing mindsets that allow positive reframing of illness and disability experiences (Koenig, 2012; Puchalski, 2013). Spirituality is an important consideration in individuals with serious illnesses and has been associated with improved quality of life of individuals and their families when incorporated in the care of these individuals (Balboni et al., 2022; Kwok et al., 2024). Additionally, experiences of illness and disability can increase existential questioning and R/S challenges (Puchalski, 2013). Much of this existing research connecting R/S and health outcomes focuses on mental health conditions, cancer, and palliative and hospice care contexts. In contrast, dysphagia, difficulty swallowing solids and/or liquids, is an understudied condition in health and R/S literature. Dysphagia occurs in about 16% of adults (Adkins et al., 2020) and can be caused by a multitude of etiologies such as stroke, traumatic brain injury, Parkinson's disease, dementia, and head and neck cancer (ASHA, 2025). Given the role of eating and drinking in religious rituals and religious and cultural social gatherings (Rourke & Leslie, 2013), more research is needed to understand the impacts of dysphagia on R/S and cultural engagement and expression. In addition, the role of R/S on coping with and meaning-making of the dysphagia experience for both persons with dysphagia and caregivers of persons with dysphagia needs to be further explored. The current study used a qualitative approach to examine these gaps in the literature through focus groups.

There are many reasons why dysphagia and its resulting limitations on eating and drinking could have a negative impact on R/S and cultural expression. Religious groups often have specific food rules and eating practices that impact food and drink choice, food preparation and serving, timing of eating, and the social environment surrounding eating and drinking (Leslie et al., 2022). For example, several religions, such as Judaism, Islam, and Christianity, include fasting practices in which adherents avoid eating for specific amounts of time or during particular periods of the religious calendar. Also, many religions have rules around eating and/or preparation of specific foods and drinks such as alcohol, meat, fish, and dairy (reviewed in Leslie et al., 2022). Dysphagia may impact an individual's ability to conform to the food rules and practices of their religion. In addition, several religions also have specific religious rituals in which food and/or drink are consumed. For instance, communion, practiced by Catholic and Protestant Christians, is one such ritual in which a piece of bread/wafer and a drink of wine/juice is consumed to remind adherents of Jesus' crucifixion and strengthen their relationship with God and the church. Nund (2014) studied the impact of dysphagia secondary to head and neck cancer on community, social, and civic life domains, reporting on a participant who described challenges they had with the communion ritual due to difficulty swallowing liquids. Rourke and Leslie (2013) also identified the social, religious, and spiritual implications of being unable to participate in communion because of dysphagia symptoms. Even beyond specific rituals, many religious social gatherings center around shared meals such as potlucks or lunches after religious services which may be inaccessible. More generally, a diagnosis of any life-altering medical condition can prompt existential questions about meaning, purpose, and relationship with God/transcendence (Puchalski, 2013) that could have R/S implications.

In contrast, R/S commitments also have positive impacts on the experience of dysphagia for persons with dysphagia and caregivers. Religious communities often provide valuable social support, especially for older adults (Koenig, 2012), a population with a high risk for dysphagia. SLPs are an integral team member in providing support to individuals at the end of life, especially with respect to swallowing function (Chahda et al., 2017, 2022; Stead et al., 2023) as well as communication needs (Chahda et al., 2021). In palliative care for dysphagia, the SLP focus "centers around balancing quality of life and enjoyment of meals against the possible risk of choking or aspiration on quality of life of the individual and enjoyment of meals" (Chahda et al., 2022, p. 77). Religious involvement has also been found to aid in the grieving process (Mathisen et al., 2015), which may be a part of the adjustment to disability experience for persons with dysphagia and caregivers. Also, positive mindsets marked by hope, optimism, and gratitude are often encouraged and cultivated in religious contexts (Koenig, 2012), which may also support a healthy coping process. Koenig (2012) presents a theoretical model that identifies the reasons that R/S could result in positive outcomes in the context of illness and disability. These include beliefs that provide meaning in the context of difficult circumstances that lead to positive emotions and feelings of purpose, optimistic beliefs about a God who loves humans and cares about their needs, provision of a sense of control and answers to difficult existential questions, and role models of loss and change that normalize these experiences as part of the human condition.

This positive role of R/S in the context of illness and disability has been examined in several studies in the speech-language pathology literature. Spirituality was identified as a powerful coping mechanism in aphasia recovery post stroke (Laures-Gore, 2018). Incorporating spirituality in assessment and treatment in speech-language pathology, as well as taking into consideration the cultural influence on spirituality, has been discussed by Mackenzie and Mumby (2022). Last, Kao et al. (2023) found that treating dysphagia in older adults during acute hospitalization resulted in increased self-ratings of R/S, regardless of whether the treatment was thickeners or swallowing exercises, in comparison with a control group who received only personalized dietary counseling. Thus, treating dysphagia symptoms more directly seemed to have positive influences on other areas of the participants' lives, including

R/S. As a whole, this literature demonstrates a potentially bidirectional relationship with R/S facilitating positive coping with dysphagia and treatment of dysphagia symptoms leading to greater R/S expression.

This recognition of the importance of addressing R/S and cultural expression in healthcare settings dovetails with the increasing emphasis on person-centered and family-centered care (Puchalski, 2013; Puchalski, et al., 2009). For example, person-centered care involves respect and dignity for patients, families, and their values, beliefs, and practices, which include religious and cultural beliefs/practices (Lundberg, 2024). Health care approaches that seek to treat the whole person involve biopsychosocial and spiritual models of care that move beyond addressing solely physical needs to include domains of psychological and spiritual functioning (Puchalski, 2013). There is also a growing recognition of the importance of interprofessional care in the context of addressing spirituality in health care settings, via collaboration between the medical team and spiritual care providers such as chaplains (Puchalski, 2009). This need for attention to R/S matters in health care has also been emphasized within the context of speech-language pathology (Mathisen et al., 2015). Given this greater attention toward incorporating R/S factors in assessment and treatment of patients, more research is needed, especially with health conditions that have received less attention in existing literature.

The current study sought to examine the interplay between religion, spirituality, and cultural expression and dysphagia for persons with dysphagia and caregivers. Qualitative data were collected through a focus group of persons with dysphagia and caregivers in order to evaluate (1) the impact of dysphagia on engagement with religious, spiritual, and cultural practices and (2) ways that religious, spiritual, and cultural beliefs impacted the experience of coping with dysphagia symptoms and caregiving.

Method

Participants

Participants for this study were attending a monthly interprofessional support group for persons with dysphagia and caregivers. The current study reports on data from two sessions of the support group that were structured as focus groups on the topic of religious, spiritual, and cultural impacts of dysphagia and caregiving.

Persons with dysphagia could participate in the support groups if they met the following criteria: (1) were 18 years or older, (2) had a diagnosis of dysphagia, (3) achieved a score of 21 and above on the Mini Mental State Examination (MMSE, Folstein, et al., 1975), and (4) could communicate in English. Caregivers could participate if they (1) were 18 years or older, (2) identified as the primary caregiver of a person with dysphagia, (3) achieved a score of 21 and above on the MMSE, and (4) if they could communicate in English. This diagnosis of dysphagia could have been documented by a health-care provider or speech-language pathologist, or it could be self-reported. Participants in this study reported a wide range of causes of their dysphagia symptoms, which included head and neck cancer, spinal surgery, Parkinson's disease, and other gastrointestinal and respiratory conditions. The caregivers were not required to be present for the person with dysphagia to participate. Both persons with dysphagia and caregivers had the option of attending sessions independently.

Once persons with dysphagia and caregivers expressed interest in joining the support groups, the screening and consent process occurred. There were five persons with dysphagia ranging in age from 76 to 84 years and three caregivers ranging in age from 78 to 81 years. Please refer to Table 1 for demographic data and results from screening procedures for persons with dysphagia and Table 2 for caregivers, respectively. Participants B and E were accompanied by their caregivers (Caregiver X and Z, respectively). Caregiver Y's spouse had dysphagia due to Parkinson's disease, but he was unable to attend the support group with her due to his advanced dementia symptoms.

Measures

Screening Measures. The measurement tools used in the current study for persons with dysphagia and caregivers were the demographic questionnaire and a screening tool for dementia (MMSE, Folstein, et al., 1975). Additional quantitative data on psychosocial impact of dysphagia symptoms, quality of life, and caregiver burden and stress were also collected at the onset and conclusion of the support group and will be reported in future published work.

Focus Group Questions. The focus group session prompts began with asking participants to identify cultural and/or R/S food rules and eating practices that applied to their specific cultural or religious groups. Then, participants were asked to discuss how these practices, rituals, and traditions had changed since their diagnosis/caregiving and how this impacted their cultural and R/S expression or experiences. Participants were asked to identify any difficulty their dysphagia or caregiving had created culturally or with regard to R/S. Questions related to the ways that their diagnosis/caregiving impacted how they functioned in their religious or cultural communities were discussed. Last, questions focused on the ways that participants' R/S impacted how they made meaning of their diagnosis or caregiving experiences. The full list of focus group questions can be accessed in supplementary materials.

Procedure

Following approval from the Institutional Review Board, participants completed informed consent and screening measures before beginning participation in the support group. The support groups were facilitated by faculty and students in nursing, psychology, social work, and speech-language pathology. Sessions were scheduled for once a month, lasting 60–90 min each. Sessions were conducted at a local senior living facility, and participation was not restricted to individuals living in the facility. Monthly sessions rotated between three different formats: sessions with an educational focus, focus-group format, and open-ended conversations with a focus on community-building and support. Data for the current study were drawn from the focus-group format sessions. During focus-group sessions, semi-structured

Table 1 Demographics of Participants with Dysphagia ($N=5$)

Information	Participant				
	A	**B**	**C**	**D**	**E**
Age (years)	76	79	83	82	84
Sex	Female	Male	Female	Female	Male
Race	White/Caucasian	White/Caucasian	White/Caucasian	White/Caucasian	White/Caucasian
Religion and Importance of Religion	Christian Very important	Christian Very important	Christian Very important	Christian Very Important	Christian Very Important
Education Level	High school	Master's Degree	Bachelor's Degree	High school plus 1.5 years of Bible college	Master's Degree
Employment Status	Retired	Retired	Retired	Retired	Retired
MMSE Score[a]	30	27	29	29	Participant was aphonic
Cause of dysphagia	Carcinoma of the throat, surgery and radiation treatments	Cervical spinal surgery	Cancer in the jawbone; surgery and radiation treatment	GERD, rhinitis, smaller esophagus, upper airway sensitivity	Parkinson's disease

[a] Mini-Mental State Examination (MMSE)

Table 2 Demographics of Caregivers of Participants with Dysphagia ($N=3$)

Information	Participant		
	X	**Y**	**Z**
Age (years)	78	80	81
Sex	Female	Female	Female
Race	White/Caucasian	White/Caucasian	White/Caucasian
Religion & Importance of Religion	Christian; very important	Christian; very important	Christian; very important
Education Level	Bachelor's degree	Bachelor's Degree	Bachelor's Degree
Employment Status	Retired	Retired	Retired
MMSE Score	30	30	30

interviews that consisted of a set of predetermined open-ended questions with prompt suggestions were used. Some prompts were preset, whereas other prompts were contingent on participants' responses and incorporated their own vocabulary. These sessions were recorded, and discussions were coded and analyzed.

Data Analysis

Thematic analysis of focus group qualitative data was conducted, where data were first categorized into thought units. The definition of thought units by Vaughn et al. (1996) "smallest amount of information that was informative by itself" (p. 106) was used for the identification of thought units from the discussion responses. Operational definitions were developed and modified to define the themes and subthemes based on the topic area in focus group discussions and participant responses (Oommen & McCarthy, 2015). At first, the thought units were categorized into subthemes and themes, following which the data were reviewed multiple times to reduce redundancy, until the final set of themes emerged that portrayed an understanding of an experience from the perspective of the people who have lived that experience.

Interrater and intrarater agreement was examined for the qualitative data at the thought unit and thematic level, with the goal of 80% agreement or higher and that differences in classification at the thought unit and thematic analysis level be resolved through discussion. This reliability was established for each session from which data were analyzed thematically and for a minimum of 20% of the data, i.e., a random selection of 20% of the responses were chosen for establishing reliability at the thought unit level and then at the subtheme and theme level. Then, the percentage of agreement was calculated, "dividing the number of agreements by the total number of agreements, disagreements, and omissions" (Oommen & McCarthy, 2015, p. 68). The overall percentage agreement for interrater reliability was established to be 85% and higher for each session. Similarly, the same procedure was conducted for intrarater reliability, and the overall percentage agreement for intrarater reliability was calculated to be 85% and higher for each session.

Results

Difficulties with Church Gatherings Centered Around Food

Participants, especially persons with dysphagia, discussed the important role food plays in church gatherings, often by bringing people together and strengthening their sense of community. Food is seen as more than just nourishment, but a way to connect others to celebrate faith. Participant D mentioned the connection in Christianity, saying,

> "I have heard or read that, faith and food... that there's a connection. And you know it even, it talks about feasting in heaven, I think. And, I don′t know any, you know, any getting together with people from a church group, or so. It always seems, there always seems to be food."

She also described how food is a regular part of church life, saying, "we have potlucks. The households take turns. So, my household is going to have a potluck after church on next week Sunday." Participants discussed that these gatherings were sometimes inaccessible or embarrassing for them. For example, Participant C said, "but it's awkward and you don't– I didn't walk to the buffet table. I took nothing from there because, there's always, well, there's danger of choking if it's something I'm not familiar with. It just takes too much effort." At times, the difficulties at these gatherings are related to the reactions or perceptions of others. Participant D shared:

> "I remember being at a funeral, and there were people there, who I had grown up with but I hadn′t seen them for years, and I got such a coughing spell, and a- at the lunch and after the funeral. It was just so embarrassing, and, and one of the guys, that you know, I knew as a boy but, growing up, but hadn′t seen in many years. He looked at me and said, 'You better change your brand.' You know, I knew he was just making a joke, but it still- it was embarrassing."

Difficult Communion Experiences

Persons with dysphagia shared how their experiences with communion had changed due to challenges with swallowing. For some, communion was something they had to adapt to, as they tried to find new ways to participate while managing dysphagia. Participant A expressed her surprise in having to navigate this unique challenge, noting, "Who would think that you were worried about choking on communion?" She described how this fear is always in the back of her mind and how she manages the situation when this fear arises, saying,

> "I was going to communion and I remember, 'what am I going to do if I can't swallow?' You know, but I would always just kind of keep it in my mouth and try to soften it, and, you know, let it go down. But, yeah, I-I'm– it's always in the back of my mind, you know."

Participant C also reflected on her experience facing this fear, recalling, "I was worried ahead of time, 'Am I going to choke on this?' Participant D described how she feels a bit out of sync during the process, saying, “When we go up front, you know, then we right away swallow the bread, and then take the cup. And, and, I feel like I’m standing there a little bit longer.” All participants described how something as central to their faith as communion required thoughtful adjustments to accommodate their limitations.

Missing Cultural Foods

Participants discussed the challenges they faced in continuing to enjoy cultural foods, particularly when managing dietary restrictions as part of their treatment. Discontinuing certain cultural foods became a significant change, as these foods were once a cherished part of their traditions and celebrations. For example, Participant C shared the difficulty of no longer being able to enjoy Ethiopian cuisine from her husband’s family’s culture, saying, “Their most special meal is Ethiopian cuisine, and…it’s so very delicious, I would love to eat it again. But it’s a challenge right now.”

Finding Resilience Through Faith

Participants discussed how their faith helped them have resilience in coping with the challenges of dysphagia. Trusting that their experiences were in God’s hands gave them a sense of peace, acceptance, and hope. For example, Participant C reflected on how her faith helped shape the way she responded to her unexpected diagnosis, stating, “I have not, you know, experienced depression from this surprising diagnosis that I got nearly a year ago. I just consider that this is all, it’s totally in God’s hands.” Through Participant C’s perspective, faith helped maintain a sense of emotional stability, and avoid feelings of hopelessness and uncertainty when navigating her diagnosis.

Finding Religious Community Support

Persons with dysphagia discussed the importance of their religious communities as a source of emotional and social support while managing dysphagia. Being part of a faith-based community offered them a sense of belonging, meaningful connections, and tangible support, which helped them cope with some of the challenges associated with dysphagia. For example, Participant D discussed the emotional benefits from church support, particularly the psychological comfort that came from communal prayers, stating, “I have felt the community, the warmth of the Christian community with many people who have prayed for me.” In addition to this, Participant C shared that her care group had become like family and that she felt comfortable doing her tube feedings during their meals together, saying, “And I felt free to do my tube feeding at the meal. They’re my care, I, they’re my care group family, actually.”

Gratitude and Positive Mindsets

Persons with dysphagia also expressed gratitude and a positive outlook for different aspects of their lives, including their faith and the care they received from their community. Participant C, for example, reflected on the ways she had been cared for throughout her experience, saying, “There have just been so many wonderful ways I’ve been cared for throughout this experience.” She acknowledged the role of her faith, stating, “There’s a lot of gratitude and so I’m very thankful, very very thankful to my Lord for that.” In addition to gratitude for her faith and community, Participant C expressed gratitude for having received proper diagnosis and treatment, saying that “the fact that I’m here and experiencing the measure of good health that I do have is a miracle in itself, to me.”

Religion and Caregiver Experiences

Caregivers reported leaning on their R/S beliefs when navigating the challenges associated with dysphagia. Many of them saw their role as a caregiver as a reflection of their religious values, and as giving them a sense of purpose. As Participant X shared, “I cannot believe how many times, and over the last few years, how many times people would say, ‘You are such a shining example’, they would say, ‘of Christ’s likeness.’” Faith also provided reassurance through difficult decisions that caregivers were required to make. Participant Y described feeling like God was actively guiding situations, sharing,

> “That one scared me [moving to the nursing floor of the facility]. I didn’t think he’d agree to that and I thought just, and God put just the right people in place for that, our social worker was just outstanding and my kids were supportive.”

In summary, caregivers used their R/S beliefs to make meaning of their caregiving experience, guide caregiving decisions, and to support positive coping in the midst of facing difficulties due to their dysphagia caregiving.

Discussion

The current study used a focus group approach to examine the interplay between dysphagia and R/S and cultural practices/experiences for persons with dysphagia and caregivers. The results revealed ways in which dysphagia served as a barrier to cultural and R/S participation and expression, including that participants mourned no longer being able to eat culturally specific foods, that certain religious rituals (e.g., communion) were difficult to participate in, and that they had negative experiences with religious gatherings that were often centered around shared meals. At the same time, several themes emerged identifying ways that R/S were facilitating positive coping and meaning-making. Specifically, participants identified that their faith had made them resilient in the face of difficulties, that it helped them maintain positive mindsets and gratitude, that faith communities provided vital support and care, and that, for caregivers, it provided a structure to make meaning from their experiences.

This mix of barriers to R/S and cultural expression while also acknowledging positive coping and meaning-making roles of R/S is consistent with the growing speech-language pathology literature examining the intersection of various conditions and religion/spirituality (Kao, et al., 2023; Laures-Gore, 2018; Nund, 2014). Our findings are also consistent with several theoretical models. For example, Koenig's (2012) model that seeks to explain connections between R/S and physical health identified three pathways by which religious involvement could improve health and longevity: psychological (coping, meaning, mental health), social (support, community involvement), and positive health behaviors. Findings in our study align well with both the psychological and social pathways, with participants identifying positive coping, resilience, meaning-making, and religious community support as key ways their R/S involvement impacted their experiences with dysphagia and caregiving. Additionally, Puchalski's (2013) spiritual model of care identifies both positive (hope, connection, meaning) and negative (isolation, demoralization, spiritual doubt) dimensions that could be assessed in addition to traditional biopsychosocial dimensions in healthcare settings. Our study findings of both R/S challenges posed by dysphagia alongside the positive role of religion and religious community in coping lend support for Puchalski's position (2013) that a nuanced and thorough view of the role of R/S is needed for holistic, person-centered healthcare (Kwok et al., 2024; Lundberg, 2024; Mathisen et al., 2015). For example, one spiritual diagnosis that Puchalski identifies is religious-specific ritual needs, in which a patient is unable to participate in their historical religious practices. This corresponds to the challenges our participants identified with engaging with communion and the anticipatory anxiety, embarrassment, and lack of spiritual connection they experienced as a result. Additionally, participants reported both the isolation and ostracism they experienced at some religious gatherings centered around food while also identifying the connection they experienced with others at religious gatherings that were inclusive and accessible to them.

The current study is an important step in expanding the literature on connections between physical health and R/S, especially in understudied conditions such as dysphagia. It also incorporates both patient and caregiver perspectives derived in the context of an interprofessional support group. At the same time, limitations in the study design should be acknowledged that point to future research opportunities that could be explored. First, all participants in our study identified as Christian and were White, older adults. The researchers made all attempts to advertise the support groups across the community as an initiative that welcomed participation from any adults with dysphagia and/or caregivers of persons with dysphagia, and support group sessions were hosted at a local community living facility to allow for maximum participation. However, the demographics of the region where the study was conducted, as well as the Christian affiliation of our universities, likely contributed to the lack of religious diversity in the sample. It would be helpful to examine the experiences of persons with dysphagia and caregivers in other racial and ethnic groups and other religious contexts, such as Islam, Hinduism, or Judaism, as food rules and rituals vary significantly across religions and cultures, and religious meaning-making approaches may also differ. Second, the sample size of the current study was relatively small. Larger-scale studies that incorporate quantitative measures would be able to examine additional research questions, such as the ways that various demographic or other psychological variables impact connections between dysphagia experiences and R/S and cultural expression. Third, while both persons with dysphagia and caregivers seemed to speak candidly in each other's presence and efforts were made to ensure all participants had a chance to answer each question, the impact of the caregiver presence on the person with dysphagia's participation and vice versa cannot be ascertained unless separate groups had been conducted.

Practical applications of our findings emerge for both healthcare professionals and religious communities seeking to utilize inclusive practices. Our study echoes others that advocate for a healthcare system that prioritizes holistic approaches that are patient and family-centered (Puchalski, 2013; Puchalski, et al., 2009). Incorporating R/S assessment and treatment into healthcare delivery for persons with dysphagia who are seeking this form of holistic care may promote positive outcomes and could assist patients and families in coping with difficult R/S and cultural impacts of their symptoms. Additionally, religious communities can explore necessary accommodations, such as using thickeners or alternative food options (e.g., dissolvable communion wafers), that would allow members with dysphagia to continue to participate in religious rituals. In some circumstances, this may require additional effort to ensure that the use of thickeners is consistent with the dietary rules of the person's religion (e.g., animal products). Rourke and Leslie (2013) discuss additional accommodations, such as delivering communion elements through a feeding tube or placing several drops of wine in the congregants mouth, that would be appropriate for individuals unable to take any food or drink by mouth. Education within religious communities about the symptoms and impact of dysphagia could also reduce stigma and isolation by allowing members with dysphagia to continue to participate in social gatherings and religious rituals with a greater degree of comfort. Prioritizing this type of inclusion could allow persons with dysphagia and caregivers to share valuable lessons about gratitude, resilience, and coping with suffering that could enrich and encourage their religious communities.

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Declarations

Conflict of interest We have no known conflicts of interest to disclose.

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