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Exploring the Interplay between Self-Care, Religious Coping, and Continuity of Care on Nutrient Intake among Sick Patients – An Interdisciplinary Model

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Abstract

The sick is an individual experiencing physical or mental issues that require medical attention, care, and support. Nutrient intake is crucial for the recovery and wellbeing of the sick as nutrient regulates the body mechanism and functions thus, aiding healing processes. Self-care practices, religious coping mechanisms, and continuity of care significantly influence patients' nutritional outcomes. This study investigates the relationship between self-care, religious coping, and continuity of care and their impact on nutrient intake among sick patients, targeted towards developing an interdisciplinary model. A purposive sampling method was used to assess 330 patients having severe illnesses who were hospitalized. Structural equation modeling and regression analysis examine the relationships between self- care practices, religious coping mechanism, continuity of care, and nutrient intake. Self-care practices (β=0.35, p<0.001), religious coping mechanism (β=0.28, p<0.003) and continuity of care (β=0.22, p<0.002) positively predict nutrient intake. The interdisciplinary model explains 72% of variance in nutrient intake. This study highlights the importance of integrating self-care, religious coping, and continuity of care to enhance nutrient intake among sick patients. Thus, healthcare providers should consider patients' self-care practices and religious coping mechanisms when developing care plans.

Keywords: *Self-Care, Religious Coping, Continuity of Care, Nutrient Intake, Sick Patients.*

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1. INTRODUCTION

Sick patient refers to any individual confronting physical or mental health challenges that require timely medical intervention, compassionate care, and ongoing support **(World Health Organization, 2018; American Hospital Association, 2020)**. Sick patients require comprehensive care that addresses their physical, emotional, psychological, and social well-being **(World Health Organization, 2018)**. Effective care involves understanding patients' unique needs, respecting their autonomy, and promoting their dignity. Physical needs of sick patients include pain management – adequate pain control and symptom relief are crucial **(American Pain Society, 2019)**; nutrition and hydration – balanced diet and adequate fluid intake support recovery **(Food and Agriculture Organization of the United Nations, 2017)**; sleep and rest – sufficient rest and sleep facilitates healing **(National Sleep Foundation, 2020)**. Emotional and psychological needs of sick patients include emotional support – empathetic communication and support alleviate anxiety and stress **(Institute of Medicine, 2011)**; psychological counseling – addressing coping mechanisms, depression, and anxiety improves mental health **(Hoyt et al., 2018)**; and social support – maintaining social connections and relationships enhances well-being **(Cohen et al., 2015)**. Challenges faced by sick patients are adherence to treatment, financial burden, stigma and social isolation **(WHO, 2019; Barnett et al., 2018; Link et al., 2018)**. Best practices for caring for sick patients include patient-centered care – prioritizing patient needs and preferences improves outcomes **(Institute of Medicine, 2001)**; interdisciplinary care teams – collaborative care involving multiple healthcare professionals enhances coordination **(Naylor et al., 2013)**; and continuity of care – coordinated care transitions and follow-up support recovery **(Coleman et al., 2017)**.

Nutrient intake refers to the consumption of essential nutrients necessary for maintaining optimal health and well-being **(Institute of Medicine, 2005)**. Adequate nutrient intake is crucial for various bodily functions, including energy production, growth and development, immune function, and chronic disease prevention **(Food and Agriculture Organization of the United Nations, 2017; World Health Organization, 2018)**. Macro nutrients provide energy and support growth and maintenance of the body tissues such as carbohydrates – 45-65% daily energy, protein – 10-35% of daily energy intake, and fat – 20-35% of daily energy intake as opined by **Institute of Medicine (2005)**. Micronutrients regulate various bodily functions and maintain optimal health such as vitamins – essential for energy production, immune function, and tissue growth **(National Institute of Health, 2020)**, and minerals – crucial for bone health, fluid balance, and nerve function **(Food and Nutrition Board, 2019)**. Factors influencing nutrient intake are socioeconomic status – impacts food accessibility and affordability **(Darmon et al., 2019)**; cultural background – influences food preferences and dietary habits **(Kittler et al., 2019)**; age and sex – affects nutrient requirements and dietary needs **(Food and Agriculture Organization of the United Nations, 2017)**; and physical activity level – influences energy expenditure and nutrient requirements **(American College of Sports Medicine, 2018)**. Consequences of inadequate nutrient intake includes malnutrition – impaired growth and development, increased disease risk **(WHO, 2018)**; chronic diseases – cardiovascular disease, diabetes, certain cancers **(Johnson et al., 2019)**; and cognitive decline – impaired cognitive function, increased dementia risk **(Calder et al., 2020)**.

Self-care encompasses intentional actions taken to preserve and enhance one's physical, emotional, and mental well-being **(World Health Organization, 2019)**. Effective self-care strategies promote resilience, reduce stress, and foster overall quality of life. Physical self-care involves exercise – regular physical activity improves mood and reduces anxiety **(Harri et al., 2017)**; nutrition – balance diet rich in whole foods support optimal health **(United States Department of Agriculture, 2020)**; sleep – adequate rest essential for physical and mental restoration **(National Sleep Foundation, 2020)**. Emotional self-care includes mindfulness – practice mindfulness to reduce stress and increase self-awareness **(Hofmann et al., 2010)**; social connections – nurture relationships with family and friends **(Cohen et al., 2015)**; and leisure activities – engage in enjoyable hobbies and pursuits. Mental self-care are self-reflection – regular self-reflection promotes personal growth and self-awareness **(Kabat-Zinn, 2003)**; stress

management – effective coping strategies reduce anxiety and improve well-being (Lazarus and Folkman, 1984); and mental health support – seek professional help when needed. Benefits of self-care include reduces stress, improved mental health, and enhanced resilience (Taylor et al., 2017; Keyes et al., 2019).

Religious coping refers to the use of religious beliefs, practices, and experiences to manage stress, adversity, and traumatic events (Pragament, 1997). It involves seeking comfort, meaning, and control through religious or spiritual means. Religious coping involves positive religious coping – seeking spiritual guidance, prayer, and religious community support (Pargament, 1997); and negative religious coping – viewing God as punitive or distant, feeling spiritually disillusioned (Exline, 2002). Factors influencing religious coping are religious orientation – intrinsic (personal) versus extrinsic (social) motivation (Allport and Ross, 1967); spiritual struggles – doubt, anger, and fear related to faith (Exline, 2002); and cultural context – influence of cultural norms and values on religious coping (Tarakeshwar, 2006). Religious coping has benefits such as emotional comfort – reduced anxiety, depression, and stress (Koenig, 2015); social support – community and belonging (Ellison, 1993); and meaning-making – finding purpose and significance (Park, 2013). Some challenges and limitations of religious coping are spiritual struggles – negative religious coping can exacerbate distress (Exline, 2002); cultural sensitivity – recognizing diverse religious beliefs and practices (Tarakeshwar, 2006); and mental health – addressing underlying mental health issues (Koenig, 2015). Religious coping is a complex and multifaceted phenomenon, influencing mental health, well-being, and resilience.

Continuity of care refers to the consistent and cohesive delivery of healthcare services to patients across different healthcare settings, providers, and time (Coleman and Berenson, 2004). Continuity of care ensures that patients receive seamless, high-quality care, addressing their physical, emotional, and social needs. Elements of continuity of care include relational continuity – ongoing relationships between patients and healthcare providers (Haggerty et al., 2013); informational continuity – accurate and timely sharing of patient information (Bodenheimer et al., 2014); management continuity - consistent care planning and coordination (Coleman and Berenson, 2004); and continuity of context – consideration of patients' social, cultural, and environmental factors (Wagner et al., 2012). Benefits of continuity of care are improved patient satisfaction, enhanced health outcomes, reduced hospitalizations and readmissions, increased patient engagement and self-management, and better coordination of care (Meredith et al., 2015; Saultz and Lochner, 2005; Jencks et al., 2009; Bodenheimer et al., 2014; Coleman and Berenson, 2004). Barriers to continuity of care are fragmented healthcare systems, lack of communication between providers, limited access to patient information, and insufficient care coordination (Wagner et al., 2012; Bodenheimer et al., 2014; Haggerty et al., 2013; Coleman and Berenson, 2004). Studies have found that continuity of care has been associated with improved health outcomes, patient satisfaction, and reduced healthcare utilization (Meredith et al., 2015); and also linked to better disease management and quality of life (Saultz and Lochner, 2005). This study examines the interplay between self-care, religious coping, and continuity of care on nutrient intake of sick patients of some selected South-East and South-South Nigerian hospitals.

2. METHODOLOGY

2.1. Participants

The participants for the study were 330 sick patients receiving treatment at ten Federal Medical Centers in the South-East and South-South Nigeria. The participants were sampled based on purposive sampling method and inclusion criteria were being diagnosed of illness by a medical doctor and an in-patient in the selected hospitals within the duration of this research.

2.2. Measures

Self-Care Inventory (SCI): is a comprehensive assessment tool designed to evaluate an individual's self-care practices and identify areas for improvement (Brown et al., 2016). The SCI aims to promote holistic well-being by measuring various aspects of self-care. It investigates self-care's impact on well-being and health outcomes (Hawkley et al., 2010). The SCI was developed through a systematic review of

existing self-care measures and expert feedback (Brown et al., 2016). It has 54 items, divided into six subscales – physical self-care (PSC), emotional self-care (ESC), psychological self-care (PYC), social self-care (SSC), spiritual self-care (SPC), and environmental self0care (ESC); with 5-point Likert scale (1 = "Never" to 5 = Always). The SCI demonstrates high internal consistency (Cronbach's α = 0.92) (Brown et al., 2016), test-retest reliability (r = 0.85) (Brown et al., 2-16), and construct validity through correlations with related measures (example, self-compassion scale) (Neff, 2003).

Religious Coping Activities Scale (RCAS): assesses individual's use of religious beliefs and practices to cope with stress, adversity, and traumatic events (Tarakshwar, 2006). The RCAS evaluates the role of religion in coping and its relationship with well-being and (mental) health outcomes (Hawkley et al., 2010). The RCAS was developed through literature review of existing religious coping measure, expert feedback from religious leaders and mental health professionals, and pilot testing with diverse samples (Tarakeshwar, 2006). It consists of 34 items, divided into six subscales – religious support seeking (RSS), religious coping (RC), spiritual connection (RC), religious meaning-making (RMM), religious forgiveness (RF), and religious avoidance (RA); with 4-point Likert scale (1 = "Not at all" to 4 = "A lot"). RCAS has high internal consistency (Cronbach's α = 0.93) and test-retest reliability (r = 0.87) (Tarakeshwar, 2006), and construct validity through correlations with related measures (example, Religious Coping Scale) (Pargament, 1997).

Patient Continuity of Care Scale (PCCS): assesses patients' perceptions of continuity of care, focusing on provider-patient relationships, communication, and coordination (Sanson-Fisher et al., 2000). The PCCS evaluates patients' experiences and satisfaction with care continuity; evaluates continuity of care in primary care, specialty care, and transitional care; investigates continuity of care's impact on health outcomes, patient satisfactions, and healthcare utilization; identify areas for improvement and monitor effectiveness of interventions. The PCCS was developed through literature review of existing continuity of care measures, patient and provider focus groups, and pilot testing with diverse patient population (Sanson-Fisher et al., 2000). PCCS consists of 20 items, divided into four subscales – provider-patient relationship (PPR), communication (COM), coordination (COO), and continuity (CON); with 5-point Likert scale (1 = "Strongly Disagree" to 5 – "Strongly Agree"). The PCCS demonstrates high internal consistency (Cronbach's α = 0.92) and test-retest reliability (r = 0.85) (Sanson-Fisher et al., 2000), also, construct validity through correlations with related measures (example, patient satisfaction) (Haggerty et al., 2004).

Healthy Eating Index-2015 (HEI-2015): was used to assess nutrient intake. HEI-2015 is a dietary assessment tool evaluating adherence to the Dietary Guidelines for Americans (DGA) and other evidence-based nutrition recommendations (USDA, 2015). The HEI-2015 scores individuals' diets based on adequacy and variety of essential nutrients; assess dietary quality in patients with chronic diseases; investigates relationships between dietary patterns and health outcomes; evaluates effectiveness of nutrition interventions and policies. The HEI-2015 consists of 13 components, divided into three categories: Adequacy (9 components)–total fruits, whole fruits, total vegetables, dark green and orange vegetables, legumes, whole grains, dairy, protein foods, seafood and plant-based protein; Moderation (3 components) – refined grains, sodium, and added sugars; Variety (1 component) – fatty acid ratio. Its scoring is between 0-100 points, with higher scores indicating better adherence to healthy eating patterns. The HEI-2015 has high reliability (Cronbach's α = 0.85) (Guenther et al., 2013), validity through correlations with biomarkers (examples serum nutrient levels) (Shapiro et al., 2016), and sensitivity to changes in dietary patterns (Krebs-Smith et al., 2010).

2.3. Procedures

The study was approved by the Health Research Ethical Committee of Federal Medical Center Umuahia, Abia State, Nigeria. The researchers presented the ethical approval to the various heads of General/Internal Medicine Departments of the 10 selected Federal Medical Centers in South-East and South-South Zones of Nigeria, in other to gain access to their sick patients who were in-patients (hospitalized) at the time of the study. Participating patients were drawn from the hospitals' general wards and

intensive care unit wards as they showed interest to participate and they (or their caregivers in situations of critical illnesses) signed an informed consent form indicating their willingness to participate in the study. The questionnaires were distributed to them and took an average of 40 minutes to complete each questionnaire.

2.4. Design and Statistics

The study applied cross-sectional research design. SPSS version 25 was used for data analysis. Pearson's correlation (*r*) analysis was conducted among the study's demographic variables, predictor and independent variables, while multiple regression was applied. Demographic variables (age, gender, marital status, duration of illness, number of children, occupation, and number of days spent in the hospital) were included as control variables in regression models. Also, interdisciplinary model was used to analyze the percentage of variance among the dependent variable (nutrient intake) and independent variables (self-care, religious coping, and continuity of care). The Macro PROCESS approach for SPSS automatically executes computations, runs the analysis, and produces more meaningful results.

3. RESULTS

Table 1 showed that the study comprised 330 participants, with a gender distribution of 120 males (36.4%) and 210 females (63.6%). The mean age was 51.5 years, with a standard deviation of 19.35. The majority of the participants were married (67.6%), have been ill between 1-3 years (56.4%), and have 4-6 children (58.2%). Close to half of the participants were artisan/self-employed (43.9%) and have spent 9-13 days in the clinic (41.6%).

Table 1: Demographic and Characteristic of the Participants

Variables	N	%	Mean	SD
Age	18 – 85		51.5	19.35
Gender				
Male	120	36.4%		
Female	210	63.6%		
Marital Status				
Married	223	67.6%		
Single	60	18.2%		
Divorced	12	3.6%		
Widowed	35	10.6%		
Education				
No Formal Education	56	17.0%		
Primary Education	83	25.2%		
Secondary Education	117	35.5%		
Tertiary Education	74	22.4%		
Duration of Illness				
Less than 1 year	91	27.6%		
1-3 years	186	56.4%		
4years and Above	53	16.0%		
Number of Children				
None	12	3.6%		
1-3	98	29.7%		
4-6	192	58.2%		
7 and Above	28	8.5%		
Occupation				
Student/Unemployed	100	30.3%		
Artisan/Self Employed	145	43.9%		
Civil/Public Servant	85	25.8%		

Number of Days Spent in Clinic				
4-8 days	106	32.1%		
9-13 days	137	41.6%		
14-18 days	45	13.7%		
19-23 days	30	9.0%		
24 days and Above	12	3.6%		

Note: SD – Standard Deviation

The findings in the correlation table (Table 2) showed that duration of illness was positively correlated with occupation (r = .12, p<.01), days spent in clinic (r = .14, p<.01), and religious coping (r = .23, p<0.01). Occupation positively correlated with continuity of care (r = .15, p<.01) and nutrient intake (r = .28, p<0.01). Days spent in the clinic correlated with continuity of care (r = .25, p<0.01) and nutrient intake (r = .09, p<0.01).Nutrient intake was correlated with self-care (r = .19, p<0.01), religious coping (r = .29, p<0.01), and continuity of care (r = .35, p<0.01).

Table 2: Correlations of demographic factors, self-care, religious coping, continuity of care, and nutrient intake

Variables	1	2	3	4	5	6	7	8	9	10	11	12
1. Age	-											
2. Gender	-.09	-										
3. Marital Status	-.32	.03	-									
4. Education	.10	.16	.32	-								
5. Duration of Illness	.16*	-.37	.21*	-.13	-							
6. No of Children	.29*	-.18	.04	.09	.23	-						
7. Occupation	.06	.10	-.12	.17*	.12**	.54	-					
8. Days in Clinic	.11	.19	.02	-.02	.14**	-.10	.15	-				
9. SC	.07	-.13	.24*	-.23	.12*	.06	.54	.43*	-			
10. RC	-.11	.05*	.11*	.15	.23**	.39	.10*	.25**	.39	-		
11. CoC	.43	.14	-.21	.13	.19	.12*	.15**	.18*	.90	.17	-	
12. NI	.19	.23*	.33	.05	.34*	.05	.28**	.09**	.19**	.29**	.35**	-

****p < .01(two-tailed); *p < .05(two-tailed). Gender (0 = male, 1 = female).**
Note: SC = Self-Care; RC = Religious Coping; CoC = Continuity of Care; NI= Nutrient Intake.

The results depicted in table 3 showed the predictive association between independent variables (duration of illness, days spent in clinic, self-care, religious coping, and continuity of care) and the dependent variable (nutrient intake). Duration of illness (β = .15, SE = .03, 95%CI = .15, .08) and days spent in clinic(β = .19, SE = .06, 95%CI = .10, .32) predicted nutrient intake. Self-care (β = .35, SE = .12, 95%CI = 1.45, .56), religious coping (β = .28, SE = .18, 95%CI = .24, .74), and continuity of care (β = .22, SE = .22, 95%CI = .22, .43) predicted nutrient intake positively.

Table 3: Hayes PROCESS macro results for predicting nutrient intake by duration of illness, days in clinic, self-care, religious coping, and continuity of care as a covariate

Variables	*B*	*SE*	B	*t*	*P*	95%*CI*
Duration of Illness	.15	.03	.08	1.45	.004	[.15, .08]
Days in Clinic	.19	.06	.32	2.45	.002	[.10, .32]

Self-Care	.35	.12	.89	4.21	.001	[1.45, .56]
Religious Coping	.28	.18	.74	1.23	.003	[.24, .74]
Continuity of Care	.22	.22	.92	1.14	.002	[.22, .43]

Table 4 shows the interdisciplinary model results of variance of demographic factors, self-care factors, religious factors, and continuity of care factors in relation to nutrient intake. The demographic factors combine have significant percentage of variance explained by each component of 23.1%, with self-care at 31.4%, religious coping at 20.5%, and continuity of care at 25.0%. All percentages were significant with self-care showing higher percentage.

Table 4: Interdisciplinary Model Results showing variance of demographic factors, self care factors, religious coping factors, and continuity of care factors

Predicator Variables	*B*	*t*	*p*	SS% of Variance
Demographic Factors				23.1%
Duration of Illness	0.15	2.53	0.012	
Days in Clinic	0.20	3.41	0.001	
Self-Care Factors				31.4%
Physical Self-Care	0.25	4.21	<0.001	
Psychological Self-Care	0.18	3.02	0.003	
Social Self-Care	0.15	3.24	0.002	
Religious Coping Factors				20.5%
Religious Support Seeking	0.22	3.81	0.001	
Religious Coping	0.15	2.61	0.010	
Religious Meaning-Making	0.43	2.09	0.004	
Continuity of Care Factors				25.0%
Provider-Patient Relationship	0.28	4.52	<0.001	
Communication	0.20	3.41	0.001	
Continuity	0.25	2.67	0.003	

Table 5 presents a summary of the interdisciplinary model, revealing a substantial explanatory power, accounting for 72% (R2 = 0.72) of the variance in nutrient intake.

Table 5: Model Summary Table

Model	R	R^2	Adjust R^2	F	p-value
Interdisciplinary Model	0.85	0.72	0.69	34.12	<0.001

4. DISCUSSION

This study examines the interplay between self-care, religious coping, and continuity of care on nutrient intake of sick patients. Findings from the study indicated that longer illness duration may impact job/career which in line with past findings **(Institute of Medicine, 2011; WHO, 2019)**. Longer illness duration leads to more days spent in the clinicwhich is in consonance with past literatures **(Cohen et al., 2015; Barnett et al., 2018)** which indicates that lengthy period of been sick begets lengthy durations of time hospitalized as patients need cure to their ailment in order to stay alive. It was also found that individuals with longer illness duration may rely more on religious coping mechanisms which is in line with some studies **(Koenig, 2015; Coleman et al., 2017)** and this suggest that sick patients who have tried several medical solution may rely on faith in a Divine being whom they sort for help when all hope fails them, thereby, giving them inspiration to keep living with their sick conditions.It is deduced that more time/days spent in the hospital may ensure continuous careand improve dietary habits which aligns with previous reports **(FAOUN, 2017; Link et al., 2018; Harris et al., 2017)**which indicated that the need for continuity of care and adequate food intake are always

emphasized on in hospitals by health professionals. Continuous care in turn may likely lead to better nutrition which correlates with improved self-care; adequate intake of proper nutrition is also an aspect of caring for self, as self-care is incomplete without adequate feeding.

The regression analysis revealed significant predictive associations between independent variables and nutrient intake. Longer illness duration and number of days hospitalized are associated with better nutrient intake which is in keeping with extant literature **(Harris et al., 2017; Taylor t al., 2019; Hofmam et al., 2020)** suggesting that nutrition of sick patients who have been sick for quite a number of years tend to improve as well as sick patients who are hospitalized for longer periods as health professionals are in constant check of their feeding and nutrition. Higher self-care scores, greater religious coping, and continuous care predicts better nutrient intake which agree with previous studies **(Tarakeshwar, 2006; Pack. 2013; Koenig, 2015)** and indicates that sick patients with proper levels of self-care, with a reasonable levels of religious coping, could indulge in adequate continuity of care experience better nutrition. This demonstrates the powerful effect of self-care, religious coping and continuity of care on nutrient intake.

The model's R2 value of 0.72 indicates a strong relationship between the predictors and nutrient intake, suggesting that the interdisciplinary approach effectively captures the complex interactions influencing nutrient intake. The integration of multiple disciplines likely contributes to the model's robust explanatory power, highlighting the importance of collaborative research in understanding complex health issues. The model's findings can inform the development of targeted interventions, guiding healthcare professionals in creating personalized nutrition plans that address specific factors influencing nutrient intake such as time spent been hospitalized, prolong illness, self-care, religious coping, and continuity of care.

5. CONCLUSION

This comprehensive study underscores the significance of an interdisciplinary approach to understanding nutrient intake, particularly for hospitalized sick individuals. The findings demonstrate a robust relationship between demographic factors, self-care, religious coping, continuity of care, and nutrient intake. Self-care strategies are crucial for nutrient intake management. Religious coping mechanisms and continuity of care significantly influence nutrient intake as well as demographic factors, such as occupation which play a notable role in nutrient intake. Interdisciplinary collaboration is therefore essential for effective nutrient intake management. Thus, healthcare providers should prioritize personalized, holistic care approaches which imply integrating self-care and religious coping strategies into treatment plans; ensure continuity of care through coordinated services; provide nutrition education and counseling; consider demographic factors in treatment plans; and foster interdisciplinary collaboration. This study contributes significantly to the understanding of nutrient intake management, emphasizing the importance of interdisciplinary collaboration and personalized care approaches. By implementing these findings, healthcare providers can improve health outcomes for hospitalized sick individuals.

Statements and Declaration

There is no conflict of interest and no competing interests. There is no financial interests related to this work submitted rather this is to unveil a new combination of an interdisciplinary approach to foster collaborations among health professionals.

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