

## Social support

## Spousal support in a behavior change intervention for cholesterol management

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## ABSTRACT

**Objective:** To evaluate spousal involvement in a nurse-led intervention for patients with high cholesterol in which patients set health goals and spouses learned support strategies.

**Methods:** Qualitative interviews were conducted with 29 patients and 26 spouses who received the intervention during a trial. Interviews were stratified by patient LDL-C change (better, same, worse). Coded text was content analyzed, and organized into thematic matrices, with columns indicating individuals (spouse or patient) and rows indicating dyads.

**Results:** Patients and spouses reported no drawbacks to spousal involvement; some patients whose LDL-C did not improve wanted more focus on spouse health. Spouses said that the nurse's expertise and interest were helpful and they were better able to communicate with patients about health. Although the program helped couples work together, spouses with better or same LDL-C talked more about functioning as a unit, whereas those whose partners had worse LDL-C talked more about functioning as individuals.

**Conclusion:** Although the spousal role was accepted, there were variations in level of involvement. More active spousal involvement might relate to better patient outcomes. For less involved spouses, more focus on their health may improve commitment or involvement.

**Practice implications:** These findings can inform ways to generate spousal support in future trials.

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## 1. Introduction

Although low-density lipoprotein cholesterol (LDL-C), the major atherogenic lipoprotein and cause of coronary heart disease, can be managed with lipid-lowering medications and lifestyle changes, few individuals persistently use these therapies [1–4]. In one study, less than half (44%) of patients with cardiovascular disease reported consistent use of lipid-lowering agents [4]. In the 2006 National Health and Nutrition Education Survey, 43% of adults reported being physically active 12 times a month, and 26% reported eating five or more fruits and vegetables a day [3]. Individuals find it difficult to integrate behavior change into their daily lives and over the long run due to lack of knowledge about benefits of changing, low self-efficacy to make changes, insufficient education and counseling by providers, inconvenience and cost of health promotion programs, and lack of long-term support. The difficulty is intensified for people with high cholesterol, who need both medication and lifestyle behavior change and have an

asymptomatic disease with no readily apparent threat [5]. Patient self-management interventions delivered by trained health educators over the telephone can effectively help patients with chronic disease address these issues and improve their health behavior [6–8].

Ongoing social support from domestic relationship partners in concert with that provided by health professionals can help patients with high cholesterol improve adherence to self-management therapies. Positive social relationships in general are associated with better health [9]; individuals can actively help their partners change by regulating the other's habits in ways that help them to meet their incremental health goals and, by achieving these goals, improve self-efficacy [10]. For example, spouses can provide emotional support by encouraging their partners to initiate and then maintain an exercise routine, or instrumental support by obtaining and cooking healthy foods [11]. Further, partners who have strong relationships tend to communicate about health and treatment options; they influence each other's health because they view the other as an important part of their lives. In less close relationships, such as between providers and patients, individuals are more willing to respond to someone whom they perceive as a legitimate source of influence, for example, by having relevant expertise or demonstrating

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benevolence [12]. Regardless of relationship type, one's actions, however well-intentioned, are not considered supportive unless perceived as such by the recipient.

The purpose of this analysis was to describe the nature of spousal involvement in a behavior change intervention for patients with high cholesterol. This intervention extended previous telephone-based self-management interventions in that the health educator helped spouses generate strategies for supporting patients' self-selected behavior change goals and plans; spouses were able to choose ways in which they implemented these strategies [13]. As part of the intervention evaluation, we conducted qualitative content analysis of interviews with participants in the intervention arm upon completion of a randomized controlled trial. Research questions were: (1) how did patients and spouses evaluate spousal involvement in an intervention focused on the patient? And (2) what were relationship processes that engendered spousal support? We were interested in exploring patterns in responses according to patient LDL-C change, the primary trial outcome, in order to generate hypotheses about relationships between spousal support and patient outcomes. Integration of qualitative and quantitative data allowed exploration of how the spousal support component, which did not have a prescribed form, might have been related to the measurable outcome, LDL-C change. Qualitative methods were well suited for unpacking the nature of spousal support; this information was integrated with quantitative data at the point of analysis to generate hypotheses about how social support might have been a mechanism for improved LDL-C [14]. Results can be used to inform design of future interventions focused on teaching spouses strategies to support their partners' health behaviors.

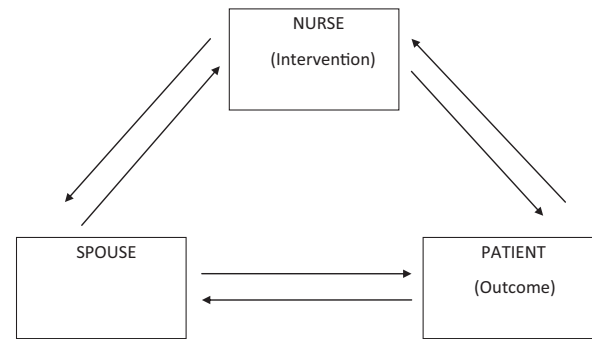
## 2. Methods

### 2.1. Setting and participants

Participants were primary care patients and spouses from the Durham Veterans Affairs Medical Center (VA) who had participated in the intervention arm of an 11-month randomized, controlled trial and agreed to a 30-minute phone interview 1–2 weeks after the last trial assessment. Our sampling intention was to obtain as many patients and spouses as possible with varied patient outcomes. Trial recruitment was conducted between November 2007 and July 2009, with follow-up completed in June 2010 [13]. Patients were identified as eligible if they had a spouse, a primary care visit within the previous 12 months, and an upcoming clinical appointment, identified via electronic medical records. Patient exclusion criteria were not married, unwilling to have blood drawn for a lipid panel, enrolled in another lifestyle change study, or high baseline LDL-C ( $>76$  mg/dL) or triglycerides  $>800$  mg/dL. Couple exclusion criteria were no telephone, impaired cognition or hearing, a health problem that would preclude participation, long-term care or nursing home residence, or hospitalization in the prior 3 months. Eligible couples were scheduled for in-person baseline assessments where they provided written consent, completed self-report measures, and received education materials; they were then randomized to intervention or usual care.

### 2.2. Intervention

Details of the intervention have been reported [15,16]. The lifestyle coaching intervention, couples partnering for lipid enhancing strategies (CouPLES), was designed to help patients adopt health behaviors important for LDL-C control with support from their spouses and the intervention nurse. Fig. 1 shows relationships that constituted this social support intervention: the nurse delivered health coaching to patients directly and through



**Fig. 1.** Conceptual model of relationships in the CouPLES intervention. This model shows that this is a nurse-delivered intervention with patient-level outcomes; spouses are involved in the intervention to help deliver messages from the nurse. Bidirectional arrows indicate that patients feed back information, for example about their preferences or barriers, for a patient-centered model.

their spouses with patients feeding back information about personal preferences and challenges. Patients and spouses received the following: (1) handouts on cholesterol, diet, physical activity, lipid-lowering medications, physician-patient communication, and spousal support and (2) monthly phone calls over 10 months from a study nurse to discuss patient-driven health goals and action plans, with spouse calls including ways to support patients. Patient calls were to be delivered first and spouse calls within one week of the patient calls; however, in some cases, patients and spouses participated together on one call or were both present in the room.

The first call to patients and spouses covered information about hypercholesterolemia and self-management principles; spouses also received tips for supporting patients, such as focusing on patient-driven goals, rather than what they thought patients should achieve. Patient choice played a central role in the content of subsequent goal-setting phone calls. Patient calls focused on goal-setting and problem-solving, with patients choosing each month from one of four behaviors important for chronic disease self-management (diet, physical activity, patient-physician communication, or medication adherence) and setting goals and action plans (i.e., specific behavior plans to achieve their goals) according to what they felt confident they could accomplish. Each month, patients chose one goal, and, in their call, reviewed progress toward their goals from the previous month. If patients did not achieve those goals, the nurse helped them generate a more realistic goal for the next month.

Spouses were to help support patients with goal attainment. During their calls, spouses were reminded of patients' goals and action plans from the previous month and informed about whether patients had reported meeting their goals. Spouses were additionally informed of patients' goals and action plans for the upcoming month. For diet or physical activity goals, spouses were asked if they planned to make the same changes as the patient; recommended support behaviors were then tailored accordingly. For example, if patients wished to walk three times per week, spouses could join them in this activity and/or verbally provide positive reinforcement. Although the intervention aimed to change patient behavior, in some cases, spouses became recipients and reported health benefits.

### 2.3. Data collection and analysis

Baseline self-reported sex, date of birth (to calculate age), race, social support for eating and exercise, global marital satisfaction, and LDL-C at baseline and 11 months were used to describe the current sample. Social support for eating and exercise were

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