

**The Impact of Social Support in Older Adult Chronic Disease Self-Management**

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**Abstract**

**Objectives:** As the older adult population grows, the number of chronic diseases in that population also increases, threatening to become a significant burden on the healthcare system. The purpose of this integrative review was to explore social support and determine the impact that it may have on older adult self-management for use in future interventions to improve quality of life and health in this population.

**Methods:** During the review, the framework of Whittemore and Knafl was used to perform a thorough search, identify articles meeting inclusion criteria, and reduce data into prevalent themes of social support.

**Results:** The results of the integrative review suggest that social support can have a positive impact and that the degree of impact is determined by the quality and type of relationship between the individual and his or her social support.

**Discussion:** Both the limited amount of research in diseases other than diabetes and the lack of focus on older adults suggest that more research endeavors focusing on social support mechanisms are needed to meet the needs of the growing population of older adults with chronic disease.

**Keywords:** social support, social networks, chronic illness, older adults, aged, elderly, self-management, and self-care

**Introduction**

Self-management in chronic disease is a technique used to enhance individual outcomes and decrease risk factors. The process of self-management is driven by the patient, but at the same time, certain variables enhance or negate self-management behaviors such as self-efficacy, setting of goals, social support, and interaction with the healthcare team (Kawi, 2012). One of these variables, social support has been successfully incorporated into self-management programs in the form of provider or peer led support groups (Chodosh et al., 2005; Lorig, Ritter, & Plant, 2005). These standardized programs have resulted in patient improvements for up to 1

year; however, long-term improvement in outcome measures has not been supported (Chodosh et al., 2005). As social support is a multidimensional concept that affects many aspects of an individual's life, further understanding of social support and its potential impact on self-management is needed.

### **Background**

The investigation of a relationship between social support and self-management behaviors is not new. A decade ago Gallant (2003) reviewed the literature regarding the relationship between self-management and social support. At that time, Gallant (2003) noted that the more personal the support the greater the benefit (Gallant, 2003), a finding which encouraged further exploration of social support. Yet, a generalization of social support prevailed and research utilized a variety of social support variables that did not clarify the relationship between specific types of support (Gallant, 2003). Diabetes management was examined in a majority of the studies resulting in a gap in knowledge regarding the role of social support in other diseases. At that time, the state of research specifically in older adult populations was minimal, and the need to understand whether social support should be assessed as a variable that could prevent or promote self-management behaviors remained (Gallant, 2003).

Not only is social support thought to impact self-management, but also it is considered a social determinant of health (SDOH). The presence of social determinants of health have been shown to increase the risk of negative health outcomes (Marmot & Wilkinson, 2006; World Health Organization, 2013), developing chronic diseases resulting in decreased life expectancy (Marmot & Bell, 2009). SDOH have been identified as catalysts in the development of chronic disease, placing a new emphasis on socio-environmental factors, such as social support, that could potentially impact health outcomes. Increasing concern regarding the impact of the socioeconomic environment on the development of chronic disease and management reinforces the need to explore social support and the role it has in self-management behaviors.

Therefore, since social support 1) may positively influence health outcomes (Gallant, 2003; Langford, Bowsher, Maloney, & Lillis, 1997) and 2) is a social determinant of health (Marmot & Bell, 2009), it is important to understand the effects of support mechanisms on self-management interventions for older adults with chronic disease. The purpose of this integrative review is to evaluate the current state of knowledge regarding social support and to analyze how social support has been studied in relation to self-management in older adults with chronic disease.

### **Social Support**

*Social support* refers to the relationships that provide a person emotional, physical, and informational support (Weinberger, Hiner, & Tierney, 1987). Social support affects an individual's health either directly or indirectly as a moderator of health status (Stansfield, 2006). As a mechanism, social support can also act as a buffering system that can blunt stressful effects of a given situation (Stansfield, 2006). An individual's ability to use social support to blunt stressful effects can act as a protective mechanism from the impact of that stress (Stansfield, 2006). The recognition of the moderating effects of social support has resulted in increased

interest in the relationship between social support and chronic illness outcomes (Stansfield, 2006). Social support, is comprised of two dimensions: *functional support* and *structural support* that are further divided into specific categories of social support (Barth, Schneider, & von Kanel, 2010).

The dimension of *functional support* includes instrumental, financial, informational, appraisal, and emotional support (Barth et al., 2010). The exchange of positive feelings and empathy is the basis for *emotional support* and the foundation for relationships. *Perceived social support* occurs when active support may not be present, but the individual perceives or feels that it is (Langford et al., 1997). The perception of perceived support by an individual in either the role of giver or receiver of support has been shown to be an important aspect of social support and has been positively correlated to health outcomes (Sayers, Riegel, Pawlowski, Coyne, & Samaha, 2008). *Instrumental support* implies tangible actions that are consistent with nurturing (Langford et al., 1997) such as giving either physical assistance or helping complete a task for a family member. *Informational support* is defined as communication that occurs in an effort to solve a problem (Langford et al., 1997). Giving advice in times of stress is instrumental support. *Appraisal support* is a type of communication in which validation or confirmation of an individual occurs (Langford et al., 1997) through the transferring of information from one individual to another to increase someone's self-esteem or feelings of competence.

The dimension of *structural support* encompasses the characteristics of an individual's social network (Barth et al., 2010; Weinberger et al., 1987), and characteristics that define with whom the social interaction takes place. Evaluating structural support includes assessing criteria such as number of friends, marital status, social contacts, and the frequency of those contacts (Barth et al., 2010; Weinberger et al., 1987). The quality and impact of those relationships can be measured as *network characteristics*. Evaluating network characteristics (Weinberger et al., 1987) is important in measuring an individual's level of satisfaction with the quality of his or her social support (Gleeson-Kreig, 2008).

### Data Sources

A literature search was completed using CINAHL, Ovid MEDLINE, PubMed databases and Google Scholar. The literature search was limited to English language studies beginning in 2002, to coincide with Gallant's (2003) previous review of literature, through August 2013. MeSH terms were identified to enhance the search results and the terms "self-care," "self-management," "chronic disease," "chronic illness," "social support," "social network," "aged," and "elderly" were chosen. The non-MeSH terms "older adult," "spouse," "peer," and "family" were also used in the search. The search was conducted utilizing various combinations of the identified search terms.

### Inclusion and Exclusion Criteria

Before comprehensive review of the studies was completed, inclusion and exclusion criteria were determined. Publications were included if they were research studies that evaluated the effects of social support or social networks upon self-management/self-care or components thereof in older adults (65 ±) with chronic disease. As only a few studies that used older adults

could be found, the inclusion criteria were adjusted to include a mean age of 55 in the sample. Articles were excluded if they were not published in English or focused on health outcomes relative to specific diseases but did not measure social support as a variable.

### **Methods**

The framework of Whitemore and Knafl (2005) guided the literature search and data analysis. The Ovid Medline search yielded 513 articles. A search of Cumulative Index to Nursing and Allied Health (CINAHL), removing duplications, resulted in 77 publications. Abstracts were reviewed individually for relevance to older adults with chronic disease and research articles were reevaluated using inclusion and exclusion criteria to determine suitability for the integrative review. This search process ultimately resulted in the identification of 15 primary research articles from Ovid MEDLINE and 6 from CINAHL for a total of 21 articles that investigated the role of social support in patient's self-management his or her disease. Searches in PubMed, and Google scholar did not yield any additional articles.

Each study was placed in a matrix to facilitate quality appraisal and synthesis of the research data (Table 3-1). The research designs included in the integrative review were randomized controlled trials (RCT), descriptive correlational research designs, descriptive comparative, cross-sectional prospective and mixed-method studies. The studies were reviewed for design, samples, measures studied, results and recommendations.

### **Results**

Using the level of evidence criteria from the *Centre for Evidence Based-Research Medicine* that rates the highest level of evidence possible as 1a, studies in the integrative review were rated at 1b (RCT) or 2c level (Centre for Evidenced Based Medicine, 2011; The Centre for Evidenced Based Medicine, 2011), which is acceptable.

### **Social Support Measurement**

After critical appraisal was completed, the data were analyzed and reduced (Whitemore & Knafl, 2005) to find specific themes relevant to research of social support. The variations in social support that were measured in the retained studies included overall social support levels, quality of social support, and perceived social support. Network characteristics measured included spousal support, family support, peer support, healthcare support, and cultural needs related to social support.

#### *Outcome Measures*

To determine the relevance of social support, researchers used common disease-specific self-management indicators to measure change. The disease that has been predominately studied in social support is diabetes. The purpose of this study was to look at social support in older adults. Only 6 articles were found to have a sample with a mean age of 65 years or greater. Patients with only diabetes mellitus type 2 were evaluated in 14 of the studies (Coffman, 2008; Gleeson-Kreig, Bernal, & Woolley, 2002b; Huang, Courtney, Edwards, & McDowell, 2010; Hunt, Grant, Moneyham, Wilder, & Steele, 2012; Hunt, Grant, & Pritchard, 2012; Khan, Stephens, Franks, & Rook, 2013; Oftedal, Bru, & Karlsen, 2011; Schiotz, Bogeland, Almdal,

Jensen, & Willaing, 2012; Tang, Brown, Funnell, & Anderson, 2008; Thom, Ghorob, Hessler, De Vore, & Chen, 2013; Venkatesh & Weatherspoon, 2013; Vest et al., 2013; Wu, Change, Courtney, & Kostner, 2012). Heart failure was the population characteristic in four of the studies (Gallagher, Luttik, & Jaarsma, 2011; Hedemalm, Schaufelberger, & Ekman, 2010; Salyer, Schubert, & Chiaranai, 2012; Sayers et al., 2008) while rheumatoid arthritis (Strating, van Schuur, & Suurmeijer, 2006) was the focus of a single study. Two studies explored diabetes with an additional co-morbidity (J. Greene & Yedidia, 2005; Wu et al., 2012). The outcome measures used to evaluate the impact of social support included changes in physical activity (Huang et al., 2010; Oftedal et al., 2011), glucose monitoring (Thom et al., 2013; Venkatesh & Weatherspoon, 2013), medication adherence (Hedemalm et al., 2010), self-efficacy (Gleeson-Kreig et al., 2002b; Hunt, Grant, Moneyham, et al., 2012; Hunt, Grant, & Pritchard, 2012), and diet (Oftedal et al., 2011; Tang et al., 2008).

#### *Partner support*

Studies in family and partner support have focused on communication, participation in the plan of care, and methods for decreasing risk factors. These studies indicated that the quality of partner support can have an impact on the individual's self-management behaviors (Gallagher et al., 2011; Oftedal et al., 2011; Sayers et al., 2008; Schiotz et al., 2012; Strating et al., 2006; Vest et al., 2013). The presence of positive partner support resulted in an increase in positive attitude towards the self-management process and increase in the intent to self-manage (Strating et al., 2006). For example, marital relationships that client's felt offered higher quality support were found to positively influence self-management (Strating et al., 2006), increased involvement by the client in the self-care process (Gallagher et al., 2011), and increased adherence to self-management (Salyer et al., 2012; Sayers et al., 2008; Tang et al., 2008). With the presence of positive marital support, increased physical activity (Khan et al., 2013), health outcomes (Huang et al., 2010), and a decrease in risk behaviors (Schiotz et al., 2012) were observed.

The role of destructive or negative relationships must also be measured when assessing the presence of spousal support as a possible mediator for increasing self-management habits. While many of the studies were small, most indicated that positive support or lack social support may impact the individual and self-management care indicating that the quality of partner support could impact self-management behaviors.

#### *Family Support*

Expanding the studies of social support to family, friends and peers is important in the older adult population. Since during the aging process the influence of social support can shift from the partner to that of family, friends, and peers, it is important to examine the social structure and determine where the older adult will expect to receive support. For the older adult, studies indicated that spousal support is most likely to be chosen (Oftedal et al., 2011) over family support that involves burdening children (Bardach, Tarasenko, & Schoenberg, 2011; Coffman, 2008; Oftedal et al., 2011); support from friends or neighbors were least favored (Oftedal et al., 2011).

As with the spouse/partner, frequent and high quality family contact had a greater influence on self-management than the number of people in the social network (Venkatesh &

Weatherspoon, 2013). Support from family can influence an individual's utilization of self-management and has shown to decrease risk behaviors (Schiotz et al., 2012). In a number of studies, when a family was more supportive and involved, the client demonstrated a greater ability to address health behaviors, symptom management (Rosland, Heisler, & Piette, 2012; Venkatesh & Weatherspoon, 2013), and increase health outcomes (Rosland & Piette, 2009). In two studies, it was found that lack of family support could have a negative impact on self-management care (Ofstedal et al., 2011; Sayers et al., 2008).

#### *Friends and Peer Support*

While older adults were least likely to rely upon friends and neighbors (Coffman, 2008; Schiotz et al., 2012), the supporting role of friends in self-management behaviors were found to influence participation in self-management care and behavior change. The presence of lack of social support among friends also related to decreased adherence and participation (Schiotz et al., 2012).

The use of peer support in the older adult was addressed in a few studies. A peer is an individual who has similar characteristics as the participant and is used to lead a group program as a role model (Thom et al., 2013). However, while peer-led self-management groups are used in practice, few studies evaluated the direct impact that the peer presence had on the self-management process. In only one study in this integrative review, was the relationship of incorporating peer support in to the self-management process compared (Thom et al., 2013; Wu et al., 2012) to a control group. In this study, the use of a peer coach to support self-management resulted in decreased blood glucose levels in the diabetic participants. The use of a peer has also been shown to increase the level of knowledge concerning self-management (Wu et al., 2012), but peer support only produced a small effect in change in self-management behaviors and self-efficacy (Wu et al., 2012). These studies were small, but the results suggest peers may have an impact on chronic disease self-management.

#### *Healthcare provider and system support*

The self-management process encourages a team approach to behavior change among the individual and healthcare providers. As the healthcare provider holds an important role in the chronic disease care process, the perspective of healthcare provider support is an important viewpoint to evaluate. Three studies found that provider communication did impact adherence to treatment regimens (R. R. Greene & Graham, 2009; Ofstedal et al., 2011; Schiotz et al., 2012). If the individual perceived positive constructive communication, that individual experienced increased self-efficacy and the completed self-management tasks (R. R. Greene & Graham, 2009). The presence of non-constructive communication by the provider resulted in less adherence by the client (Ofstedal et al., 2011; Schiotz et al., 2012).

#### *Gender*

Not only is it important to measure the levels of social support and the impact they can have on an individual, but also it is important to understand if other factors such as gender or ethnicity impact the role of social support. In this integrative review, only two studies specifically addressed the impact of gender on social support in self-management (Hunt, Grant, Moneyham, et al., 2012; Hunt, Grant, & Pritchard, 2012). The results suggested that there may be differences between men and women in the response to social support and the impact on self-

management, but these findings are tempered by small sample sizes and disproportional gender presence in the studies.

### *Ethnicity*

Since cultural differences may shape an individual's view of social support or determine levels of influence on the individual, several studies have evaluated the role of ethnicity and culture on support. Three of the studies evaluated social support in specific ethnic populations (Coffman, 2008; Gleeson-Kreig, Bernal, & Woolley, 2002a; Venkatesh & Weatherspoon, 2013). Both Coffman (2008) and Gleeson-Krieg (2002) focused upon tangible or task-oriented support in Hispanics' with diabetes. In the case of Hispanics with diabetes, levels of tangible support impacted levels of diabetes self-efficacy, a significant component of self-management programs since higher levels of self-efficacy have been shown to increase self-management behaviors (Udlis, 2011). Coffman (2008) also found that within this ethnic and disease-focused study, depression also indicated an increased perceived need for tangible support. Gleeson-Krieg, Bernal, and Wooley (2002) measured levels of social support and found that while the Hispanic population had a large social network, Hispanic individuals still demonstrated increased tangible support needs, suggesting that the number in an individual's network is not as important as the satisfaction with existing support. The differences in cultural perspective should also be taken into account when evaluating social support in self-management interventions. For example, in the study by Venkatesh and Weatherspoon (2013) Asian-Indian diabetics perceived additional social support needs related to dietary cultural differences in which their normal diet, consisting of high carbohydrates (Venkatesh & Weatherspoon, 2013), must be altered to meet lower carbohydrate recommendations. The participants voiced concerns that the healthcare provider might not understand their dietary needs (Venkatesh & Weatherspoon, 2013) and the cultural preferences related to diet. Hedemalm et al., (2010) found that in the immigrant population adherence was higher in the presence of lower social support (Hedemalm et al., 2010). While increased adherence promotes health outcomes, the presence of lower social support in older adults has been linked to increased mortality (Mazzella et al., 2010) suggesting that the lack of social support in immigrants should be furthered studied.

### **Discussion**

The purpose of this integrative review was to identify research studies that explored mechanisms of social support in relation to self-management in older adults with chronic disease. Overall, despite small samples sizes, the majority of studies indicated that a relationship between social support and self-management levels exist. They also indicated that cultural and ethnic differences may impact self-management and should be part of the self-management education process for providers. This relationship between social support and self-management cannot be conclusively applied to the older adult population due to the relatively small number of studies in the specific population.

Findings from the integrative review indicated a positive relationship among spousal/partner, family, and peer support and self-management behaviors. At the same time, studies indicated that lack of support could be detrimental to self-management behaviors, and as

the older adult relies on the partner for support, evaluating the quality of that partner support is important to assess for successful self-management. In the studies reviewed, the presence of partner support was associated with increased self-management behaviors. Thus, inclusion of partners in the self-management process should be further investigated in interventional studies to determine if improving partner support can impact self-management levels.

While family is perceived as a source of social support, older adults appear to be less likely to utilize family to prevent unnecessary burden. Research focusing on the inclusion of friends in self-management support suggested the existence of a positive relationship, but as the older adult favors social support from friends the least, efforts towards improving social support through partner support would be more beneficial. When partner support is not available, alternative methods should be pursued. Peer support also appears to have positive benefits. However, in the older adult population, the peer is the least likely to be asked to provide support a situation that could hinder peer-led self-management programs for older adults.

To measure the effect of social support, studies utilized disease-specific outcome measures consistent with those utilized in self-management plans such as blood glucose control for the diabetics. In the integrative review, the field of diabetes self-management more prevalently studied than other diseases. As there are many other common chronic diseases prevalent in the United States, an increasing emphasis should be placed on the most common causes of morbidity, disability, and mortality and the influence that social support may have on self-management behaviors. The number of studies focusing on specifically diabetes type 2 supports the need to broaden the field of diseases being investigated related to the role of social support in self-management

### **Implications**

While our understanding of the role of social support in self-management has expanded since Gallant's integrative review in 2003, this current review indicated that social support has the potential to be an important mediator of self-management and that attention to social support mechanisms in self-management should be a growing focus. The number of studies relevant to the older adult population is small resulting in a lack of generalizability that requires more research with the older adult population.

For future research, the findings suggest a need to investigate many avenues of support such as quality of support, perceived satisfaction, and cultural barriers. The results of the integrative review encourage the development of further research questions and interventional research to conclusively evaluate the mechanisms of social support and the impact upon self-management in the older adult population. Few studies were found that solely addressed the adults over 65 years. Thus, all studies included in the review had a mean sample age of 55 years or greater. This finding demonstrates a gap in the literature in older adult research and indicates that the role of social support in the older adult must be explored to develop effective self-management behaviors in this population. Future studies should also determine if the role and emphasis of social support in older adults differs from that of other populations.



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Article Author	Social Support Variable	Country Origin	Study Design	Sample /Statistical Method	Purpose/Results/ Findings	Limitations	Conclusions/ Recommendations	LO E
Thom, D.H. et al. (2013)	Peer Support	U.S.	RCT	-Diabetics -Mean Age: 55 N=299 >50% Female Low income clinics	<b>Purpose:</b> Evaluate the impact of peer health coaches on glycemic control in comparison to a group receiving usual care.  <b>Findings:</b> Decrease in HbA1c levels in the group that received coaching at 6 months.	The low income population may not allow the findings to be generalized to the overall population. The intervention took place at the same clinic and there may have been influence on the control group by the coached group.	1. Future studies should evaluate the use of peer coaching and how to support the peer coaching process.	2b
Vest, B.M. et al. (2013).	Social Capital	U.S.	Pilot Qualitative with Semi-structured interview	-Diabetics -Urban Age mean: 58 N=34 -77% Female -65% married /partner -60% less than high school education	<b>Purpose:</b> Evaluate impact of access to social capital and relationship to self-management care  <b>Findings:</b> -Overprotection behaviors by spouse produces negative focus on promotion -Higher preventative activities in individuals with spouses who had high level of participation -Other roles of spouse not a mediator	Length of time since diagnosis could alter results, low response rate, Cannot make assumptions about the causal relationship due to design.	2. Need further studies to look at role of partner support in increasing preventative activities in self-management	2c
Venkatesh, S. & Weatherspoon, L. (2013).	Social Support and Health care provider support	U.S.	Qualitative Exploratory Study	<b>Sample:</b> Diabetes Asian Indians N=30 Age:50%>60 51% male Well educated	<b>Purpose:</b> Compare social support and healthcare support between two groups ;one with control HgbA1C and one group without Controlled HgbA1C <b>Findings:</b> -Those with better social support had greater outcome control -Most satisfied with provider unless worked in health care field -Physician ranked second behind family in level of support -Concerned about physician lack of knowledge regarding ethnicity (i.e. diet) -Want family involved	Several participants were healthcare workers which could present a bias, convenience sampling	1. Recognize that healthcare provider and family social support may impact outcomes in self-management  2. Stress importance of cultural needs such as social expectations in gatherings barrier to adherence (diet)	2c
Khan, C.M. et al. (2013).	Spousal support	U.S.	Descriptive Correlational Pilot Study	<b>Sample:</b> Diabetics N=70 couples Age 55 or older 87% white	<b>Purpose:</b> look at the impact of daily spousal support on exercise <b>Findings:</b> Daily spousal support has positive effect on activity engagement  The more spousal control resulted in less activity	Short observation period, spouse physical activity not assessed, readiness to change not assessed	<b>Recommendations:</b> 1. Need study with experimental design to manipulate spousal involvement to solidify findings	2b
Hunt, C.W. et al. (2012).	Social support	U.S.	Cross Sectional Descriptive Correlational Analysis	<b>Sample:</b> Diabetics N=152 Age: 56%>51 years of age. 65% female 58.6% African American Rural Convenience	<b>Purpose:</b> Examine the relationship between self-efficacy, social support, social problem solving, and diabetes self-management  <b>Findings:</b> Effect of social support varied by gender -Social support was significantly related to self-management in men Social support was not a mediator between self-efficacy and self-management	<b>Limitations</b> Convenience sample, Small sample of men so cannot conclusively draw inferences, low internal consistency on measurement subscale	<b>Recommendations:</b> 1. Need further study to examine relationship in men and to determine If a specific type of social support had greater impact	2b
Hunt, C.W. et al. (2012).	Social Support	U.S.	Correlational Pilot Study	<b>Sample:</b> Diabetics Convenience	<b>Purpose:</b> Explore the relationship between self-efficacy, social support, social	<b>Limitations:</b> Pilot study, Small sample size,	<b>Recommendations:</b> 1. Assess self-	2b

				sample N=50 >50% over age of 50 Rural 62% female 60% African American	problem solving, and self- management  <b>Findings:</b> -Higher education association with increased self-efficacy -Level of social support correlated with level of self- efficacy  -Positive relationship between social support and self- management	Cannot draw conclusions as only two variables can be examined at a time	efficacy 2. Plan developed with patient 3. Collaboration with healthcare provider	
Salyer, J. et al. (2012).	- Perceive d level of social support; -Spousal support -Social network Size	U.S.	Secondary Analysis	<b>Sample:</b> Heart Failure N=97 Age mean-56 56% men 45% African American 55% Married	<b>Purpose:</b> Examine the effects of relationships on self-care behaviors and evaluate the moderating effects of self-care confidence  <b>Findings:</b> Social support has a positive influence on self-care behaviors The amount of confidence mediates the relationship between social support and self-care	<b>Limitations:</b> Decreased response to initial survey, Small sample size, Secondary analysis limits variables can study, Due to limitations in data could not effectively measure network size or impact	<b>Recommendation s:</b> 1. Further testing needed to support findings and explore causal relationships	2b
Wu, C.J. et al. (2012)	Peer support	Austr alia	RCT	<b>Sample:</b> Cardiac patients with diabetes N=30 92% Male Mean Age: 71	<b>Purpose:</b> Develop and evaluate a self-management program using peer support  <b>Findings:</b> Those that received Peer Led CDSMP had higher levels of knowledge. Only a small change was seen in self- efficacy and self-management	<b>Limitations:</b> Small Sample size, unable to evaluate gender, control group received usual care and not a self-management program that was not peer led.	<b>Recommendation s:</b> 1. Further investigation of team approach. Peer support should be further investigated for impact on self- management behaviors	2a
Bardach, S.H. et al. (2011)	- Emotion al - Tangible - Affection ate Function al	U.S.	Mixed Method	<b>Sample:</b> 76% Hypertension 68% Arthritis 37% heart disease 29% diabetes Appalachia Age mean=63 N=41 97% white 71% female	<b>Purpose:</b> Look at relationship of social support to self-management  <b>Findings:</b> -strongest support affectionate - But rated perceived support lower -hesitant to use family support due to burden so does not involve family in self- management - Narrative Theme: Self-reliance -Each member in social network had a different perceived role	<b>Limitations:</b> Small sample size; Need to evaluate overall disease burden, trajectory, and specific diseases	<b>Recommendation s:</b> 1. Self- management may provide support for those who desire self- reliance in the Appalachian population	2b
Gallagher, R. et al. (2011).	Partner Support	U.S.	Cross sectional Descriptive Design	<b>Sample:</b> Heart Failure Hospitalized Age mean=72 N=333 66% Male 56% Partner Race not reported	<b>Purpose:</b> -Partner support from multiple aspects -While scored higher on functional and emotional, the quality of support was lower. -Only 58% of partners were perceived as having sufficient knowledge of disease self-care process -Higher level of support resulted in higher levels of self-care	<b>Limitations:</b> Secondary source for data; Compared sources with and without partners and need to evaluate other sources of support	<b>Recommendation s:</b> 1. Social support that is provided to client must be of quality in order to influence self- care behaviors. 2. Partners should be included in the plan of care	2b
Oftedal, B. et al. (2011).	Perceive d Social Support	Norw ay	Descriptive, Cross sectional design	<b>Sample:</b> Diabetics N=375 F=45.6% Mean Age: 58	<b>Purpose:</b> 1. Evaluate the relationship of perceived social support, self-efficacy, and self-management motivation.  <b>Findings:</b> 1. Correlation between support and exercise 2. Correlation between constructive family support and exercise	<b>Limitations:</b> Self-report; decreased percentage of individuals with family support; cross sectional design subject bias; convenience sample lack of definitive	<b>Recommendation s:</b> 1. Patients perceive constructive support from HCP, but less supportive from family. 2. Suggest that social support may provide motivational benefits.	2b

					3. adherence Non-constructive communication with provider decreased adherence the longer the individual had been diagnosed	psychometrics	3. HCP approach communication should be evaluated for effectiveness between confrontational and non-confrontational communication	
Schiotz, M.L. et al. (2011).	Structural and Functional Support	Denmark	Descriptive	<b>Sample:</b> N=2572 Type II diabetics from a diabetic center  66% men Mean Age: 60 Convenience Sampling	<b>Purpose:</b> 1. Evaluate structure and function of social support and self-management behaviors in type II diabetics  <b>Findings:</b> 1. Contact with friends increased behaviors 2. Living with resulted in decreased risk behaviors 3. Decreased perceived support results in decreased activation	<b>Limitations:</b> Self-administered and reported instrument; Function only measured one way	<b>Recommendations:</b> 1. More focus on structure support in patient education 2. Evaluate the avenues for use of the social network to encourage self-management activities. 3. Evaluate alternate social networks and effects on self-management behaviors	2b
Hedemalm, A. et al. (2010).	Functional Support	Sweden	Comparative descriptive design	<b>Sample:</b> Heart Failure N=23 immigrants N=46 comparison group  Female: 56% immigrant group 41% Swedes Mean Age: 75	<b>Purpose:</b> 1. In heart failure patients compare differences in social support, emotional state, physical limitations, and self-care between native and immigrant Swedes  <b>Findings:</b> 1. Immigrants had significant difference in the ability to confide in someone 2. Immigrants had increased adherence 3. Mortality higher in immigrant group with lower social support (overall few deaths)	<b>Limitations:</b> Multiethnic sample may have interfered with study participation; Limited access to healthcare records to confirm heart failure	<b>Recommendations:</b> 1. Increase awareness of immigrants need for possible increased social support 2. Need more cultural sensitive measures	2b
Huang, M.F., et al. (2010).	Emotional/Tangible/Affective/Positive social interaction	Taiwan	Descriptive Correlational Design	<b>Sample:</b> Diabetes N=334 >40 years of age (specific age not reported)	<b>Purpose:</b> 1. To evaluate adaptation related to health outcomes and self-management and to determine the protective role of social support, physical activity, and coping  <b>Findings:</b> 1. Protective factors (social support) and the relationship to adaptation supported. 2. Risk factors and adaptive behaviors not correlated.	<b>Limitations:</b> convenience sample; initial testing of a theoretical model	<b>Recommendations:</b> 1. supports the inclusion of protective factors in future research relevant to diabetes	2b
Coffman, M.J. (2008).	Tangible Support	U.S.	Descriptive correlational study	<b>Sample:</b> Diabetics -Convenience sample -Hispanic -N=115 adults Mean Age: 69 -N=43 Males -N=72 Females	<b>Purpose:</b> 1. Examine the relationships among tangible support in diabetic Hispanic patients.  <b>Findings:</b> 1. Those with lower level of support have lower self-efficacy 2. No association	<b>Limitations:</b> Small convenience sample; possible altered responses based on paired interviewing; Self-report for diagnosis and survey tools	<b>Recommendations:</b> 1. results support need for increased tangible support in diabetes care 2. supports that disease specific support from family directly	2b

					<p>between depression and diabetes self-efficacy</p> <ol style="list-style-type: none"> <li>Depression and diabetes resulted in increased need for tangible support while self-efficacy remained unchanged.</li> <li>Lower education level correlated to lower levels of self-efficacy.</li> </ol>		<p>impacts adherence</p> <ol style="list-style-type: none"> <li>Recommend inclusion of a support intervention directed at self-care interventions such as diet and exercise</li> <li>include depression screening in diabetes care</li> <li>Social support network important in improving non-adherence.</li> </ol>	
Sayers, S.L. et al. (2008).	Structural Support	U.S.	Non-experimental descriptive correlation	<p><b>Sample:</b> Heart Failure N=74 Mean Age: 56 55.4% African American  96% Males  Convenience sample  Cardiology clinic at VA and University and affiliated center.</p>	<p><b>Purpose:</b></p> <ol style="list-style-type: none"> <li>Evaluate the impact of social support on outcomes through effect on self-care</li> </ol> <p><b>Results:</b></p> <ol style="list-style-type: none"> <li>Marital status and cohabitation resulted in greater social support</li> <li>Married couples had greater involvement in medical care.</li> <li>Of social network, spouse most involved.</li> <li>Emotional support with moderator of race indicated white, unmarried subjects had lower level of perceived support.</li> </ol>	<p><b>Limitations:</b> Majority of sample was male which prevented gender comparisons; convenience sampling may lead to bias; Questionnaires were self-reported.</p>	<p><b>Recommendations:</b></p> <ol style="list-style-type: none"> <li>Need longitudinal study of self-care as a mediator of social support over extended time period.</li> <li>Evaluate direct effects of positive social support on self-care.</li> <li>Further research to examine the inverse relationship between spousal support and patient self-care confidence.</li> </ol>	2b
Tang, T.S., et al. (2008).	Level, Quality, and source of support	US	<p>Cross-sectional, observational design</p> <p>Symbolic Interaction Theory</p>	<p><b>Sample:</b> N=89 African American adults with Type 2 diabetes  Mean Age: 60 67% Female</p>	<p><b>Purpose:</b></p> <ol style="list-style-type: none"> <li>Evaluate the presence of diabetes related social support.</li> <li>Evaluate social support and the relationship of self-management and diabetes related quality of life</li> <li>Identify social support specific predictors to self-care behaviors and diabetes related quality of life.</li> </ol> <p><b>Results:</b></p> <ol style="list-style-type: none"> <li>General Disease specific Social support important in diabetes self-management and quality of life.</li> <li>Social support a predictor of higher levels of self-management and quality of life.</li> </ol>	<p><b>Limitations:</b> Cross-sectional data sample cannot predict causality; did not include all types of social support; single race study so response could vary by ethnicity</p>	<p><b>Recommendations:</b></p> <ol style="list-style-type: none"> <li>Incorporation of social support training for patients</li> <li>Teach clients positive versus negative support</li> <li>Include family in teaching concerning support in self-management process.</li> </ol>	2b
Strating, M.M, et al. (2006).	Partner	Netherlands	<p>Cross sectional</p> <p>Exploratory study</p>	<p><b>Sample:</b> Age 20-70 with Rheumatoid Arthritis Mean Age: 61  N=87 (married or co-habiting)  N=26 men N=61 women</p>	<p><b>Purpose:</b></p> <ol style="list-style-type: none"> <li>Test partner support and self-efficacy as determination of self-management behaviors</li> <li>Includes the measure of intent to self-manage</li> </ol> <p><b>Results:</b></p>	<p><b>Limitations:</b> Cross-sectional design; self-report of behaviors; Findings cannot be generalized; all participants had partners</p>	<p><b>Recommendations:</b></p> <ol style="list-style-type: none"> <li>need validity and reliability of instruments used to evaluate self-management</li> <li>potential barriers and moderators</li> </ol>	2b

					<ol style="list-style-type: none"> <li>partner support and attitude were significant</li> <li>partner support was not significant to physical self-management</li> <li>perceived support effects intention of client to self-manage</li> </ol>		should be investigated	
Greene, J. et al. (2005).	Provider Support	U.S.	Descriptive Correlationa l	<b>Sample:</b> Asthma and Diabetes N=959 Age: 67.9  56.4% male Clinic setting	<b>Purpose:</b> develop a patient measure of provider support in self-management  <b>Findings:</b> Majority had positive perspective toward provider relationship and those with positive relationship had more self-care confidence.	<b>Limitations:</b> Instrument used to measure provider support had not been validated in previous studies.  Self-report instrument	<b>Recommendations:</b> 1. Further testing of instrument to determine validity 2. Recognized importance of provider role in self-management	2b
Heisler, M. & Piette, J.D. (2005).	Peer Support	U.S.	One group intervention al study	<b>Sample:</b> Diabetics N=76 Age Mean=65.6 100% Male 78.8% White VA setting	<b>Purpose:</b> To evaluate the impact of a bi-directional peer support program  <b>Results:</b> 70% stated found peer found calls helpful in managing care 73% stated improved self-care with partner support 70% stated decreased risk behaviors with peer support	<b>Limitations:</b> VA setting not generalizable, Small pilot study	<b>Recommendations:</b> 1. Need larger randomized control trial 2. Need initial peer training to be supportive	2b
Gleeson-Krieg, J., Bernal, H.B., & Woolley, S. (2002).	Social network, perceived satisfaction, and overall impact of social support	U.S.	Cross-sectional survey design	<b>Sample:</b> Diabetes Hispanic Opportunistic sample N=95 Low education, low income, majority non-English speaking Mean Age: 60 Female: 68%	<b>Purpose:</b> Examine social support effect on self-management in IDDM Hispanics  <b>Results:</b> <ol style="list-style-type: none"> <li>High quantity in social support network</li> <li>High level of task related support needed</li> <li>Lack of relationship between social support and self-management</li> </ol>	<b>Limitations:</b> Need instrument to adequately measure social support	<b>Recommendations:</b> <ol style="list-style-type: none"> <li>Continue to research social support in disease specific self-management</li> <li>Rural versus urban my show difference in instrumental support</li> <li>Need longitudinal studies of social support</li> </ol>	2b