ABSTRACT

THE RELATIONSHIP BETWEEN SOCIAL SUPPORT AND HEALTH-PROMOTING LIFESTYLE BEHAVIORS IN UNINSURED ADULTS

By Kasey A. Coey-Boerner

The role that health-promoting lifestyle behaviors play in the prevention of chronic disease has been widely studied and reported. However, only a limited number of studies have addressed the relationship between social support and health-promoting lifestyle behaviors. Gaps in the literature exist regarding the relationship between these variables in uninsured individuals. This study was undertaken to explore whether or not social support influences health-promoting lifestyle behaviors, specifically in an uninsured adult population.

The research questions addressed in this study included: (a) Is there a relationship between social support and health-promoting lifestyle behaviors in uninsured adults? (b) Is there a relationship between social support and select demographic characteristics of uninsured adults? and (c) Is there a relationship between health-promoting lifestyle behaviors and select demographic characteristics in uninsured adults. Pender’s revised Health Promotion Model (1996) provided the theoretical framework for the study.

This descriptive, correlational design investigated whether a relationship exists between social support and health-promoting lifestyle behaviors in uninsured adults. The study also compared demographics, such as age, gender, marital status, income, and educational level among uninsured adults with social support, as well as with health-promoting lifestyle behaviors. A convenience sample of uninsured adults at a northeastern Wisconsin free clinic was obtained. Data was obtained via a demographic survey, the Duke-UNC Functional Social Support Questionnaire (DUFSS) and the Health Promoting Lifestyle Profile II (HPLPII). Data was analyzed per descriptive and inferential statistics. Pearson’s r was used to determine the correlation between perceived social support and health-promoting lifestyle behaviors. T-testing was used to analyze the differences between demographic factors and perceived social support and health-promoting lifestyle behaviors. The alpha level was set at p<0.05.

Results indicate that there is a significant relationship between perceived social support and health-promoting lifestyle behaviors in uninsured individuals. The results of the DUFSS revealed mean perceived support scores that represent that the population has some perceived social support but would like more. The HPLPII revealed a mean health-promoting lifestyle score that indicated that the population sometimes engages in health-promoting behaviors.

There was also a significant relationship discovered between perceived social support in White uninsured individuals and non-White uninsured individuals. White uninsured individuals appear to have higher perceived social support than non-White uninsured participants.
THE RELATIONSHIP BETWEEN SOCIAL SUPPORT AND HEALTH-PROMOTING LIFESTYLE BEHAVIORS IN UNINSURED ADULTS

by

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In the last two decades, health promotion and disease prevention have been at the forefront of healthcare in the United States due to high costs of care and increasing rates of chronic disease. The high cost of health care in the United States exceeds any other country (Henry J. Kaiser Family Foundation, 2009). In 2007, healthcare spending equaled about 2.2 trillion dollars which is an eight fold increase since the 1980’s (Henry J. Kaiser Family Foundation). Chronic diseases are a major source of death and illness in the United States and throughout the world. The Centers for Disease Control (CDC) (2008) stated that 1.7 million Americans die from a chronic illness each year. Over the years, increased attention has been focused on understanding and emphasizing the prevention of chronic disease. In 1979, *Healthy People -- The Surgeon General’s Report on Health Promotion and Disease Prevention: Objectives for the Nation* established national goals addressing health promotion, health protection, and preventative health services (Pender, Murdaugh, & Parsons, 2002). As a result of these goals, progress was made in the control of blood pressure and smoking reduction, while death rates for heart attack and stroke decreased. As national attention increased surrounding disease prevention and health promotion, more objectives were identified. In the following years, *Healthy People 2000 & Healthy People 2010* were published, which included goals to reduce health disparities and increase access to preventative services (United States Department of Health and Human Services [USDHHS], 2000). Issues addressed include physical activity, obesity, tobacco and substance abuse, immunization, and access to health care (USDHHS).

Substantial literature reinforces the importance of promoting and maintaining healthy lifestyles to prevent chronic illnesses, which includes engaging in physical
activity, eating healthy, maintaining a healthy weight, smoking cessation, and immunization (Chiuve et al. 2008; Ford et al. 2009; Franz et al. 2002; Lichtenstein et al. 2006; Rimm & Stampfer, 2004). Lichtenstein et al. state that improving diet and lifestyle is a critical component to preventing cardiovascular disease. Fifty percent of deaths and illness in the United States are directly related to unhealthy lifestyles, primarily related to tobacco use, poor diet, unmanaged stress, and lack of physical activity (Division of Nutrition and Physical Activity and National Center for Chronic Disease Prevention, 2007). Efforts in nursing research must be undertaken to better understand the factors that affect health-promoting lifestyles. These research efforts are essential to prevent negative health effects of unhealthy lifestyle behaviors. The National Institute of Nursing Research (NINR) supports research of nurse scientists that is aimed at improving the health and healthcare of individuals. This includes research that explores psychosocial and lifestyle factors that impact health (NINR, 2006).

A psychosocial factor that affects health-promoting behaviors and healthy lifestyles is social support. Cohen, Underwood, and Gottlieb (2000) state that social support affects mental and physical health through its influence on cognition, emotions, and behaviors. They describe social support as a social network’s “provision of psychological and material resources” (Cohen, 2004, p. 676). Cohen affirms that social support provides instrumental, informational, and emotional aid. He also describes that social support improves health outcomes through two main mechanisms: (a) stress buffering and (b) main effects. Stress buffering emphasizes that social connections provide material and psychological resources needed to cope with stressors. The main effect model illustrates that individuals who participate in a social network are subject to peer pressure that will influence health behavior without regard to stress. For example,
social networks may influence whether an individual exercises. Inclusion in the social network may cause an individual to feel a responsibility to take care of themselves so they may take care of others. Interaction with others is also thought to increase positive affect and motivate individuals to care for themselves. According to the view of social identity theorists, social support can be health-promoting because it facilitates adherence to medical regimens (DiMatteo, 2004). They also believe that social support can also be health-promoting because it facilitates healthy behaviors, such as eating well, exercise, and not smoking (Uchino, 2004). Having many social ties results in multiple sources of information that could influence behaviors. A 1979 landmark study by Berkman and Syme, regarding social integration as a predictor of physical health, found that healthy adults who experienced greater social integration at the start of the study had lower mortality rates 9 years later compared to more isolated study counterparts (Cohen, 2001). Since then, many have cited the benefits of social support and positive health outcomes (Cohen, 1988; Berkman & Kawachi, 2000; Uchino, 2004). Hurdle (2001) states that greater utilization of cancer screening methods, such as occult blood and mammography examinations among women, was related to social support. Perceived lack of social support was related to higher incidences of obesity, self-reported heart conditions, mental health problems, less fiber consumption, and smoking status (Cadzow & Servass, 2009).

Socioeconomics and lack of health insurance affects health-promoting behavior and healthy lifestyles. Forty-six million Americans do not have health insurance (National Coalition on Health Care, 2009). Lack of insurance creates a substantial barrier to access preventative services and health and lifestyle education, as often these individuals do not have a consistent source of healthcare (Cadzow, Servoss & Fox,
Lacking a constant source of healthcare has been shown to result in worse health outcomes (Baker, Sudano, Albert, Borawski & Dor, 2001).

Significance of the Problem

Considering the vast amount of literature supporting how health-promoting lifestyle behaviors affect chronic disease outcomes, it is essential for advanced nursing practice to focus on factors that influence health-promoting behaviors in efforts to combat chronic illness. In primary care, advanced practice nurses (APN) are responsible for educating patients and families about health promotion and healthy lifestyle behaviors and motivating patients to engage in these behaviors. It is essential that primary care practitioners understand how influences, such as social support and lack of insurance, can affect these behaviors. Advance practice nurses may then individualize care of their patients in regard to these influences. Also, understanding how lack of insurance may influence health-promoting lifestyle behaviors may provide a new perspective to practitioners regarding community based interventions aimed at relevant populations.

Statement of the Problem

The role health-promoting lifestyle behaviors play in the prevention of chronic disease has been widely studied. Factors that influence health-promoting behaviors are not fully understood, especially in the case of social support. Many studies have addressed the relationship between social support and mortality and physiological health effects (Berkman & Kawachi, 2000; Boutin-Foster, 2005; Cohen, 1988; Cohen, 2001; Cohen, 2004; Lucas, Orshan, & Cook, 2000; Lyyra & Heikkinen, 2006; Mahon,
Yarcheski, & Yarcheski, 2004; Rimm & Stampfer, 2004; Roelfs & Shor, 2008; Uchino,
2004). Few studies have addressed the relationship between social support and health-
promoting lifestyle behaviors in uninsured individuals (Adams, Bowden, Humphrey, &
McAdams, 2000; Cadzow & Servass, 2009). This study explored whether or not social
support influenced health-promoting lifestyle behaviors, specifically in an uninsured adult
population.

Purpose of the Study

The purpose of this correlational study was to investigate if a relationship exists
between perceived social support and health-promoting lifestyle behaviors in an
uninsured adult population, as well as to explore if relationships exist between social
support, heath promoting lifestyle factors, and select demographic factors.

Research Questions

The following research questions were addressed:

1. Is there a relationship between social support and health-promoting lifestyle
   behaviors in uninsured adults?

2. Is there a relationship between social support and select demographic
   characteristics of uninsured adults?

3. Is there a relationship between health-promoting lifestyle behaviors and
   select demographic characteristics in uninsured adults?
Definition of Terms

Conceptual Terms

**Social Support:** The existence or availability of people on whom an individual can rely that know, care about, value, and love them (Sarason, Levine, Basham, Sarason, 1983).

**Health Promotion Lifestyle Behaviors:** A pattern of individual practices that is directed toward optimal well-being, personal fulfillment, and productive living (Pender, 1996).

**Uninsured Adults:** Those mature individuals having no health insurance or government assistance for healthcare.

**Select Demographic Characteristics:** Specific attributes of a population.

Operational Definitions

**Social Support:** A measure of those whom an individual perceives as providing emotional and tangible support, as measured by the Duke-UNC Functional Social Support Questionnaire (Appendix D), an eight-item, 5-point Likert scale questionnaire.

**Health Promotion Lifestyle Behaviors:** A pattern of self-initiated actions and perceptions that serve to maintain or enhance wellness, self-actualization, and fulfillment of the individual as measured by the Health Promotion Lifestyle Profile II (Appendix E), a 52-item, 4-point response questionnaire. Dimensions of the instrument measures include (a) spiritual growth, (b) interpersonal relations, (c) nutrition, (d) physical activity, (e) health responsibility, and (6) stress management.

**Uninsured Adults:** Those males or females 18 to 64 years of age that do not have a source of health insurance or government assistance for healthcare.
Select Demographic Characteristics: Specific attributes of a population, such as age, gender, marital status, income, and educational level as measured by a demographic questionnaire (Appendix C).

Assumptions

This study was based on the following assumptions:

1. Participants will respond honestly when filling out questionnaires.
2. Individual’s social, biological, and lifestyle behaviors interact and transform the individual over time.
3. Primary care practitioners constitute a portion of an individual’s support network, which has the potential to influence the individual’s health-promoting lifestyle behaviors.

Summary

The purpose of this study was to investigate whether a relationship exists between social support and health-promoting lifestyle behaviors in uninsured adults. Establishing healthy lifestyle behaviors is essential to combating chronic illness. Determining how psychosocial factors, such as social support, affect health-promoting lifestyle behaviors is also essential to the prevention of chronic disease. Findings from this study may aid advanced practice nurses in providing nursing interventions aimed at increasing social support and health-promoting lifestyle behaviors.

In Chapter I, the significance to nursing practice, problem statement, research questions, assumptions, and conceptual and operational definitions were presented. In
Chapter II the theoretical framework that guides this study and a review of the literature is provided.
CHAPTER II
THEORETICAL FRAMEWORK AND REVIEW OF LITERATURE

Introduction

In this chapter the theoretical framework and review of pertinent literature is presented. A case study is also presented that demonstrates application of Pender's Health Promotion Model (Figure 1).

Theoretical Framework

The theoretical framework guiding this study was based on Pender's revised Health Promotion Model (Pender et al., 2002). This model attempts to portray the multidimensional nature of individuals, as a result of the interactions of their interpersonal and physical environments as they try to achieve health. The health promotion model incorporates constructs from the social cognitive theory of Bandura and the expectancy-value of human motivation theory of Feather (Pender et al.). It provides a framework to investigate the biopsychosocial processes that motivate people to take part in a comprehensive health-promoting lifestyle, as well as specific behaviors that enhance health.

This model has been used successfully to explain overall health-promoting lifestyles and behaviors. The model focuses on five key concepts: individual characteristics and experiences, behavior specific cognitions and affect, commitment to a plan of action, immediate competing demands and preferences, and behavioral outcomes (Figure 1). Pender et al. (2002) acknowledge that each person has unique characteristics and experiences that affect their actions. She identifies two variables that
affect behavioral outcomes: (a) prior related behavior and (b) personal factors. Prior related behavior addresses how behaviors that the individual has engaged in, directly and indirectly, impact the likelihood of engaging in health-promoting behaviors. Personal factors address how biologic, psychological, and sociocultural factors can effect thinking, affect, and health behaviors. Behavior-specific cognitions and affect are variables that influence motivation. These variables influence the commitment to change or occurrence of health-promoting behaviors. The variables include perceived benefits of interaction, perceived barriers to interaction, perceived self-efficacy, and activity-related affect. Pender suggests that cognition variables, such as interpersonal influences and situational influences, in combination with behavior-specific variables can help determine health-promoting behaviors. Commitment to a plan of action is the variable that functions to initiate the behavioral event. Commitment pushes the individual to engage in the behavior unless a competing event or preference interferes with strategies to carry out the behavior. Immediate competing demands and preferences are those variables that interfere with the course of action to carry out the behavior. Competing demands and preferences differ from barriers as they are unanticipated. The last concept, behavioral outcome, is the ultimate health promotion behavior goal and is aimed at improving health, enhancing functional ability, and improving quality of life.

Efforts to achieve health behavior outcomes are directly and indirectly affected by interrelated multifaceted variables. The relationship between the factors influences process, decisions, and participation in health-promoting behaviors. Identifying the interrelatedness of specific variables is essential to promote research in nursing that focuses on how to support healthy lifestyle behaviors of their patients.
Pender (1996) states that social support is a subset of interactions that are supportive and involve reciprocal processes that provide the individuals with comfort, assistance, information, and encouragement, as well as promoting coping and satisfaction in life. She believes that social support is a basic human need that fluctuates throughout a lifespan and varies under different conditions. She defines it as, “the subjective feeling of belonging, of being accepted, loved, esteemed, valued and needed for oneself, not for what one can do for others” (Pender, 1996, p. 257). She also cites different mechanisms about how social support relates to health. It may be directly linked by promoting healthy behaviors or through the provision of resources or education. Social support may also provide a sense of meaning to life, self worth, and increased sense of control. It may also enhance neuroendocrine and immune responses (Pender). Perceived adequacy of social support has the potential to influence the achievement of health promotion, health maintenance, and chronic disease prevention. Social support and its affect on health may be influenced by other variables, such as age, gender, ethnicity, and socioeconomic status.

The purpose of this study was to investigate whether a relationship exists between social support and health-promoting lifestyle behaviors in uninsured adults. Pender’s revised Health Promotion Model provides insight into why social support, gender, age, and socioeconomic status may interact to affect health-promoting behaviors in these individuals. Individual characteristics, such as gender, age and being uninsured may affect health-promoting behaviors. An individual’s past experiences, such as high levels of social support and success in achieving health-promoting behaviors, may increase perceptions of self-efficacy and increase motivation. Alternatively, having low levels of social support and not successfully attaining health-
promoting behaviors may reinforce lack of participation in health promotion behaviors. According to Pender (2002), behavior-specific cognitions and affect represent motivation for intervention and are subject to modification through nursing practice. For instance, interpersonal influences, such as lack of support networks, or negative social support influences can adversely influence health-promoting behaviors. Individuals may lack feedback, motivation, encouragement, and reinforcement from those around them to aid them in achieving goals. In the uninsured population, lack of social support from healthcare providers in the form of education or encouragement may negatively affect health-promoting behaviors. The uninsured may perceive socioeconomic status as a barrier to some health promotion behaviors. Commitment to a plan of action may be affected by lack of social support as individuals may not have a strategy to pursue their outcome. Pender (1996) states that a patient having commitment without a strategy often results in failure to perform a valued health behavior. Social networks can provide information and education to the individual to help determine a strategy.

Pender’s Revised Health Promotion Model (Figure 1) provides a framework to understand how social support and demographic factors may influence health promotion behaviors in uninsured adults. Use of this model to help identify the interrelatedness of cognitive, personal, interpersonal, situational, and behavioral factors, as well as previous behaviors and their affect on health promotion, is essential to primary care nursing in order to promote effective nursing interventions and improve health promotion behavior outcomes in patients.
Figure 1. Pender's Revised Health Promotion Model (1996)
Case Study

Joe is a 30-year-old single White male. Joe does not have any family members (lack of interpersonal influences) that he is close to, but has a few close friends (interpersonal influences) that he trusts and confides in. He is employed but has been without health insurance (situational influence) for 5 years, as his current employer does not offer insurance benefits. He has not had a complete physical in 6 years and has not participated in any preventative screening programs for his health due to lack of insurance and cost related to medical tests (barrier to preventative action). In the last 2 weeks, Joe has noticed some pain and swelling in his scrotum. He is afraid to seek medical care due to cost (barrier to immediate action), but does not feel right and is worried that something is wrong. Joe asks his friends what they think. One of his friends tells him that he should be seen by a healthcare provider, as he just recently had a physical. His nurse practitioner informed him after doing his testicular exam that men age 19 to 35 years of age are at greatest risk of developing testicular cancer. He informed Joe about doing self-testicular exams each month. After discussing this with his friends, Joe researched testicular cancer online and did a self-testicular exam (commitment to plan of action). He felt a lump in his left testicle. He immediately went to a local urgent care clinic to be evaluated (behavioral outcome) in hopes of preventing worsening of the problem and due to his concern about testicular cancer (perceived benefits of action). After being evaluated and having blood drawn, Joe was sent for an ultrasound that revealed orchitis versus cancer. Though Joe was not found to have testicular cancer, he learned the benefits of preventative health screenings and health-promoting behaviors based on this experience (prior related behavior). Joe remains
uninsured but found a free clinic (commitment to plan of action) that he utilizes for annual physical exams and preventative screening modalities (behavioral outcome).

Review of Literature

In this section, literature regarding social support, health-promoting lifestyle behaviors, and uninsured health will be discussed. The review will summarize relevant literature published in the last 20 years that addresses social support and its influence on health-promoting lifestyle behaviors in different populations.

Social Support

Callaghan and Morrissey (1993) conducted a review of the literature regarding the importance of social support and health. They addressed literature from medical, psychological, and social research and concluded that social support may play an important role in maintaining health, and that its effects on health may be related to demographic traits, such as age, sex, culture, and personality traits. The authors feel more data is needed from experimental studies to validate the data already obtained in correlational studies examining social support and health.

Finfgeld-Connett (2005) clarified the concept of social support in her meta-synthesis of findings from 44 qualitative studies and three linguistic analyses. The author concluded that nurses should encourage patients to use social support and enhance social support networks to improve physical and mental health. However, because social support differs within contexts, the author recommends that efforts be undertaken to differentiate social support from other concepts.

The relationship between social support and mortality has been established. Lyyra and Heikkinen (2006) studied the effect of perceived support on all-cause mortality
at a 10 year follow up including potential mediators. They assessed perceived social support in 206 men and women 80 years of age and older and calculated survival time from last baseline exam date. They found significant risk of death in women in the lowest category of non-assistance related social support versus women in the highest category when controlling for variables. No association was made between perceived social support and mortality in men. Roelfs and Shor (2008) undertook a meta-analysis of 261 articles from studies published from 1912 to 2008 that examined the relationship between social support and mortality. They stated that three-quarters of the studies they reviewed indicate that higher levels of social support are associated with lower risk of death.

DiMatteo (2004) completed a meta-analysis of 122 studies from 1948 to 2001 regarding the correlation between social support and adherence to medical treatment. She found practical support, such as that of cohesive family relationships, to have the highest correlation with adherence. Adherence was found to be lower in families in conflict. Being married or cohabitating with another showed a modest increase in adherence.

Studies addressed in this section suggest that social support may play a role in maintaining health by decreasing mortality and increasing adherence to medical regimens (DiMatteo, 2004; Lyyra & Heikkinen, 2006; Roelfs & Shor, 2008). The studies also suggest that social support in combination with some demographic factors may play a role in maintaining health (Callaghan & Morrissey, 1993). Some conflicting results exist regarding the relationship between social support, gender, and mortality (Lyyra & Heikkinen, 2006).
Health-promoting lifestyles and behaviors have been studied in various individuals in nursing research since the 1980’s. Gillis (1993) focused on identifying the determinants of health-promoting lifestyles in children, adolescents, and adults through a review of literature of 23 studies from 1983 to 1991. He found that self-efficacy and social support were the strongest predictors of a health-promoting lifestyle. The author suggests using qualitative methods in combination with quantitative methods to create rich data. Also, she suggests replication of many of the studies analyzed with use of varied samples and random selection. Other suggestions include development of age appropriate instruments, specifically for young and elderly populations and exploration of other varied interpersonal, situational, and behavioral variables that may influence health-promoting behaviors.

Wang (1999) assessed predictors of health-promoting lifestyles among a convenience sample of 599 elderly women from three ethnic groups in Taiwan. He found, through stepwise regression, that living with others provides individuals with an environmental resource that could help to facilitate health-promoting lifestyle by providing support, interaction, and enhancing motivation. He concluded that women who live alone should receive more attention from community nurses and other healthcare providers to enhance the health-promoting lifestyle. Specific nursing interventions should be determined after a thorough assessment of ethnic background, age, education, living conditions, health history, and patient perceptions of a health-promoting lifestyle.

In a correlational study of 84 community dwelling adults, Acton and Malathum (2000) found that love/belonging need satisfaction predicted engagement in health-
promoting self-care behavior. They also found that age, gender, and ethnicity were not associated with health-promoting self care behavior. Those better educated and employed engaged in healthier behaviors than those who were not. The authors suggest that future studies involve random sampling to clarify and confirm the findings of this study as a convenience sampling was used for this study. Also, they suggest that sampling should include ethnic minorities, as well as those with lower socioeconomic status.

Lucas et al. (2000) conducted a convenience sampling of 107 community-living older adults and used canonical correlational analysis to study the role that cognitive-perceptual factors and modifying factors play in participation in health-promoting behaviors. They found that demographic variables, such as age, marital status, race, and education made significant contributions to health-promoting behaviors, like physical activity, nutrition, spiritual growth, and interpersonal relations. The authors recommend that future studies focus on larger samples of culturally diverse older women over time to allow for comparative analysis.

Researchers Pullen, Walker, and Fiandt (2001) described the determinants of health-promoting lifestyle behaviors in a descriptive correlational study of 102 community-dwelling rural older women. The researchers found that having a greater number of resources for health information, including professional, personal, and media sources, as well as provider counseling, were significantly linked with health-promoting lifestyle behaviors in these women. They stated that younger age was associated with attempts to make health-promoting lifestyle changes in a greater number of areas. Also, those who lived with someone or a spouse engaged in more frequent health-promoting
lifestyle behaviors. Further research is warranted to study specific interventions that empower women to participate in decision making to enhance health.

Qi, Phillips, and Hopman (2006) explored the associations between individual characteristics and health lifestyle behaviors, as well as utilization of preventative screening. After analyzing data from 13,756 persons who were surveyed via the Canadian National Population Health Survey, they concluded that the presence of a regular medical doctor was associated with increased rates of preventative screenings and lower rates of smoking. Also, they found an association between preventative screening and healthy behaviors with demographic characteristics, such as income and education. Those with higher household income were more likely to have had a mammogram or Pap smear, drank less alcohol, were non-smokers, and were more physically active. Higher education level was associated with non smoking, not drinking in excess, and increased physical activity. Less educated women were less likely to have a previous Pap smear.

Beal, Stuifbergen, and Brown (2009) conducted a study to describe health practices of women with fibromyalgia and predictors of a health-promoting lifestyle in these women. They studied 198 women who participated in a randomized clinical trial to test the effectiveness of a health promotion intervention for women with fibromyalgia. They found that social support was a predictor of a health-promoting lifestyle. The authors state that social support and self-efficacy were stronger influences on health-promoting lifestyle behaviors than demographic factors.

These studies suggest that social support and some demographic characteristics, such as, gender, income, education, and ethnicity influence health-promoting lifestyle behaviors (Lucas et al., 2000; Pullen et al. 2001; Qi et al., 2006;
Wang, 1999). Some conflicting results regarding age, gender, and ethnicity warrant the need for larger, randomized, and culturally and socioeconomically diverse studies (Acton & Malathum, 2000).

**Social Support and Health-Promoting Lifestyle Behaviors**

Cadzow and Servass (2009) analyzed the relationship between social support and the prevalence of self-reported mental and physical health problems. A sample of 289 patients at a free clinic completed questionnaires regarding social support and the presence of certain health conditions. They found that social support has a significant relationship with income. Those with higher income reported more social support. There was no association between social support and race, age, ethnicity, or employment status. Perceived social support was significantly linked to certain behavioral characteristics, such as eating habits and smoking status. Results of the study also indicate relationships between social support and specific health conditions. Those with insufficient perceived social support had higher frequencies of obesity, heart conditions, previous myocardial infarction, and anxiety. The authors concluded that there was an association between the sufficiency of social support and the occurrence of physical and mental health conditions, as well as income and behavior/lifestyle situations that affect health status. The study’s small sample size and depth of questioning prohibited regression analysis that could have suggested how variables interact to influence social support and the degree of variability in social support.

Mahon et al. (2004) studied the relationship between social support and positive health practices in 148 adolescents through their meta-analysis of predictors of positive health practices referenced in the literature since 1983. In the study, social support had
a strong relationship to positive health practices in early adolescents. The demographic variables, sex and income showed the least influence on positive health practices.

McNicholas (2002) conducted a cross-sectional correlational study to evaluate the relationships between positive health practices and social support, optimism, and self-esteem in 202 middle age adults 40 to 60 years of age. The researcher concluded that social support had a significant relationship with positive health practices and was positively related to self-esteem and optimism in middle age adults. Future studies identifying and testing other variables should be done to achieve a better understanding of positive health practices.

Jackson (2006) examined the impact of perceived social support resulting from close interpersonal relationships on health practices in men and women 17 to 77 years of age from a community based sample. A multivariate analysis of covariance was done to assess gender differences in perceived close support and health practices. Women reported better dietary practices, adherence to medical exams, and less substance abuse than men. No differences were found between gender and reported physical exercise, adequacy of sleep, and perceived social support.

In regard to women, better health practices were related to being older and more educated. Women participants’ perceptions of increased close social support were related to better dietary practices, willingness to participate in routine medical exams, increased exercise, and decreased substance abuse independent of sociodemographic variables. Lack of random sampling prevents generalizability of these results. The cross sectional design clarifies the relationships between sociodemographics, social support, and health practices, but it does not allow for causality. Extended periods
prospective studies should be done to clarify the causality between how social support and sociodemographics affect health practices.

Adams et al. (2000) studied the relationship between social support and health-promoting lifestyle of 400 randomly selected rural women through descriptive correlational design. The women were surveyed via the Health-Promoting Lifestyle II questionnaire and the Personal Resource Questionnaire. The researchers found that social support was a strong predictor of whether participants participated in health-promoting behaviors. There was also a statistically significant relationship between levels of education, social support, and health-promoting lifestyles. The researchers recommend future studies that address the relationship between social support and health-promoting lifestyles in rural non-Caucasian women. Also, they recommend conducting future studies that focus on interventions that enhance social support and health promotion lifestyles.

Allen, Stoddard, and Sorensen (2008) prospectively assessed the relationship between social network characteristics and adherence to mammography screening practices. They found that in a stratified random sampling of women 40 to 51 years of age, the perception that family and friends approved of mammography screening produced a doubling of the odds of having a recent mammogram. Women who reported encouragement from family or friends to participate in mammography screening were more likely to have a mammogram. The homogeneity of the sample prevents generalizability of the results, as most participants were white, insured, educated, and had health insurance. Also, the self-report method for mammography dates may have been unreliable and lead to over reporting of mammography screening adherence.
An article published in the California Journal of Health Promotion by Vidourek and King (2008) presents a review of qualitative literature from 2001 to 2007 regarding nutrition education programs targeting low income women. They discuss the main themes gleaned from the literature, one of which was recommendations to include social support and physical activity to improve dietary behaviors. They state that a study conducted by Parker and Keim (2004) (as cited by Vidourek & King, 2008) concluded that perceived lack of support is a significant barrier to improving dietary behaviors. They also state that a main theme of several studies indicated that increasing social support increased nutritional program effectiveness.

Boutin-Foster (2005) evaluated the types of social support perceived by patients with coronary artery disease as being most helpful in health behavior modification. The results of the qualitative study indicated that types of instrumental social support that facilitated behavior changes, such as making dietary changes, keeping doctor appointments, and exercising, were those that made it easier to engage in healthy behaviors, alleviated stress, and promoted the process of receiving medical care. Specific social network support people were not identified in this study and may have provided greater detail in order to tailor specific interventions. The extent of behavior change realized by participants was not assessed in this study. Future longitudinal studies might be conducted to assess if those with greater social support achieved better health outcomes.

Eyler and Vest (2002) studied the environmental and policy factors related to physical activity in rural White women. Six focus groups were conducted with 33 women, ranging in age from 20 to 50 years, who did not regularly engage in exercise. Women in these groups reported that exercising would be easier if they had someone to
hold them accountable to do it. They also expressed that having someone to go with would be a motivating factor.

Emmons, Barbeau, Gutheil, Stryker, and Stoddard (2007) completed a cross-sectional study of fruit and vegetable intake and physical activity. They found that in men, stronger social networks and influences were associated with greater fruit and vegetable intake, when controlling for variables. In women, social norm influences, such as having friends that ate the recommended amount of fruits and vegetables, had increased fruit and vegetable intake, when controlling for variables. Also, likelihood of physical activity was higher in those with increasing social networks and social support. The researchers indicate that future studies aimed at identifying variations in characteristics of social norms within families and communities with different demographic characteristics would help to develop targeted interventions and address unique needs of the groups.

Each study identified in this review indicated that social support positively affected various health-promoting behaviors. Social support was related to better dietary practices, greater fruit and vegetable intake, alleviating stress, willingness to participate in routine medical exams, increased physical activity, and decreased substance abuse (Allen et al., 2008; Boutin-Foster, 2005; Emmons et al., 2007; Eyler & Vest, 2002; Jackson, 2006; Mahon et al.; McNicholas, 2002). Insufficient social support was linked with the occurrence of physical and mental health conditions (Cadzow & Servass, 2009; Vidourek & King, 2008). These relationships were established across the lifespan from early adolescents to elderly men and women. The literature also indicates that gender, age, and educational status may be mediating variables in the relationship between social support and health-promoting lifestyle behaviors (Adams et al., 2000; Jackson,
2006). It seems however, that many of these studies are not generalizable, due to small or homogenous samples. Future research aimed at studying this relationship should be directed at large, random, heterogeneous samples.

Uninsurance and Health

The landmark study of the Institute of Medicine (May 2002) regarding the consequences of uninsurance concluded that adults who do not have health insurance coverage do not get the healthcare that they need and are more likely to have poor health and premature death than those insured individuals. The researchers state that the best health outcomes are possible only if those uninsured obtain health insurance coverage before the onset of illness. They stated that uninsured adults are less likely than those insured to obtain recommended health screening services. Having insurance will not only increase access to care in crisis, but also will allow for essential health screening services and care of chronic disease.

Hadley (2003) conducted a review of the literature and analyzed 54 studies from 1991 to 2001 regarding the relationship between health insurance, medical care use, health, work, and income. Hadley concluded that uninsured individuals have a significantly higher risk of death than those insured.

The Robert Wood Johnson Foundation (2005) summarized the most recent data from the National Center for Health Statistics National Health Interview. Nearly half of all uninsured, non-elderly adults report having one chronic health condition. They also found that uninsured adults with chronic conditions such as diabetes, hypertension, and high cholesterol suffer significant gaps in needed health care.

Cadzow et al. (2007) explored health status and the social and economic correlates of 469 adults, 20 years of age and older at a free urban clinic. The authors
found that those individuals with less than a high school education had a higher prevalence of diabetes, hypertension, and history of myocardial infarction. They state that low income and uninsured populations often have less health related knowledge, interfering with their ability to seek care and ask appropriate questions, as well as lack of access to a regular source of care. Limitations of the study included that a precise response rate could not be calculated, as the number of questionnaires distributed was not calculated, and self-report method used to collect data may have biased the results. Also, many questionnaires were not complete.

Ayanian, Weissman, Schneider, Ginsburg, and Zaslavsky (2000) conducted a random household telephone survey in all 50 states of 105,764 adults, ages 18 to 64 years, regarding health status, health insurance, presence of diabetes, smoking, a variety of health screening modalities, immunizations, and weight control. They found that adults who rated their health status as good, fair, or poor were two to three times more likely to have been uninsured 1 year or longer than those who reported very good or excellent health. Smokers, binge drinkers, and obese individuals were more often uninsured than those without these risk factors. However, they also found that those with self-reported hypertension, diabetes, and hyperlipidemia were less likely to be uninsured than those without the conditions. Long-term uninsured adults (>1 year) were more likely than insured adults to have unserved needs for preventative services.

In summary, uninsured adults are less likely than those insured to obtain recommended health screening services (Institute Of Medicine, May 2002). Thus, these individuals suffer with chronic conditions, such as diabetes, hypertension, and hyperlipidemia, resulting in higher risk of death than those insured individuals. Compounding the effect of lack of insurance on chronic conditions, low income and
uninsured often have less health related knowledge, interfering with their ability to seek care and ask appropriate questions, as well as lack of access to a regular source of care (Cadzow et al. 2007). Also smoking, binge drinking, and obesity are often also related with uninsurance (Ayanian et al.). Having health insurance prevents chronic illness, increases education, and lowers mortality by allowing for health screening services and access to care in crisis (Hadley, 2003).

Summary

Pender’s Revised Health Promotion Model (1996) was used as the theoretical framework for this study. Several concepts of Pender’s model, such as individual characteristics, behavior-specific cognitions, and affect and behavioral outcome, were presented and their relationship to social support, demographic characteristics, and health-promoting behaviors reviewed. In a review of the literature, studies indicate a positive relationship between social support and mortality, as well as health-promoting lifestyles (Adams et al., Allen et al., 2008; Beal, Stuifbergen, & Brown, 2009; Boutin-Foster, 2005; Jackson, 2006; Lyyra & Heikkinen, 2006; Mahon et al., 2004; McNicholas, 2002; Roelfs & Shor, 2008; Wang, 1999). Other studies conducted regarding the predictors of health-promoting behaviors were also presented. It was found that social support and demographic variables, such as age, gender, income, education, marital status, and employment, consistently influence health-promoting lifestyle behaviors (Callaghan & Morrissey, 1993; DiMatteo, 2004; Emmons et al., 2007; Pullen et al., 2001; Qi et al.). Consistent findings also validated that uninsured individuals often have poorer health, poorer health outcome, and are less likely to receive preventative care (Ayanian et al., 2000; Hadley, 2003; Institute Of Medicine, May 2002; Robert Wood
Johnson Foundation, 2005). Though many studies have examined the relationship between social support, mortality, health-promoting lifestyle behaviors, and certain demographics, this study will be undertaken because there is a lack of research regarding the relationship between these variables in the uninsured population.

In Chapter III, the research design, sample, setting, data collection instruments, and data analysis are presented. Guidelines for protection of human subjects and limitations of the study are also presented.
CHAPTER III  
METHODOLOGY  

Introduction  
The purpose of this study was to investigate if a relationship exists between social support and health-promoting lifestyle behaviors in uninsured adults, as well as relationships between select demographic characteristics and each of the variables. In this chapter the design of the study, population, sample, setting, data collection, and data analysis procedures will be discussed.

Design  
A descriptive, correlational design will be used to determine the relationship between social support and health-promoting lifestyle behaviors among uninsured adults. Correlational design is appropriate because it measures the tendency for variation in one variable to be related to variation in another variable (Polit & Beck, 2008). For example, in this study increased social support may be related to increased health-promoting lifestyle behaviors. The descriptive design allows for comparison of demographic factors, such as age, gender, marital status, income, and educational level among uninsured adults with social support, as well as with health-promoting lifestyle behaviors.

Population, Sample, and Setting  
The target population for this study will be multiethnic, English-speaking, uninsured adults, ages 18 to 64 years. The accessible population is multiethnic,
English-speaking, uninsured adults, 18 to 64 years of age who utilize a northeastern Wisconsin free clinic. The sample will be convenience from uninsured adult patients at a northeastern Wisconsin free clinic.

Inclusion criteria include:

1. Participants can read English
2. Participants have no source of private, employer or government-based health insurance
3. Participants are male and female aged 18 to 64 years

Exclusion criteria include:

1. Pregnancy
2. Diagnosis of mental retardation, mental disability
3. Legal incompetence

Data Collection Instruments

Three instruments were used for data collection: (a) a demographic questionnaire (Appendix C), (b) a social support questionnaire (Broadhead, Gehlbach, Gruy, & Kaplan, 1988) (Appendix D), and (c) a health-promoting lifestyle profile (Walker & Hill-Polerecky) (Appendix E). Permission to use and alter the social support questionnaire was granted via email correspondence with Dr. Gehlbach, one of the authors of the tool. Permission for use of the health-promoting lifestyle profile is granted from the author in published literature and on the author’s website (The University of Nebraska Medical Center & College of Nursing, 2007). The demographic questionnaire was developed by the researcher for this study.
The second instrument that was used was the Duke-UNC Functional Social Support Questionnaire (DUFSS) (Appendix D) (Broadhead et al., 1988). The DUFSS allowed participants to rate their satisfaction with the functional properties of social support, such as affective and confidant support that they receive from members of their social support network. The eight-item questionnaire uses a 5-point rating scale, from “much less than I would like” (1 point) to “as much as I would like” (5 points). A summary score is obtained by adding all of the item scores. Subscores for affective and confidant support can also be obtained by adding the scores for each item category, respectively. Examples of items from this questionnaire include:

1. I have people who care what happens to me
2. I get love and affection
3. I get invitations to go out and do things with other people

The DUFSS was originally designed as a 14-item questionnaire that addressed the following four content areas: relations with confidants, affective support, quantity of support, and instrumental support. After testing the 14-item DUFSS, instrumental assistance and quantity of support items were found to be unreliable and were deleted from the instrument. The remaining eight items address affective support (Items 1, 2, 8) and confidant support (Items 3, 4, 5, 6, 7). Adequate reliability and test-retest correlations were established in a sample of 410 established family practice patients 18 years of age or older. Two-week test retest reliability for the items varied from 0.50 -- 0.77. The average of the item-total correlations specific to the content areas were 0.62 for confidant support and 0.67 for affective support. Dimensions of affective and confidant support meet criteria for face validity and content validity, as the items in the questionnaire were based on current literature and are designed to address many
aspects of social support that were measured in the study. Concurrent validity was demonstrated by statistically significant correlations when comparing affective and confidant support with other measures of social support activities in three of the four activities.

The third instrument that was utilized was the Health-Promoting Lifestyle Profile II (Walker & Hill-Polerecky, 1996). This questionnaire was used to assess the frequency of self-reported health-promoting behaviors in the areas of health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management. The 52-item scale uses a 4-point response format from “never” (1 point) to “routinely” (4 points). Scoring is obtained by calculating a mean from all 52 responses. Then, a mean of each subscale is calculated. Examples of items from this questionnaire include:

1. Choose a diet low in fat, saturated fat, and cholesterol
2. Exercise vigorously for 20 or more minutes at least three times a week (such as, brisk walking, bicycling, aerobic dancing, using a stair climber)

Validity and reliability were established in a study of 712 adults, ages 18 to 92 years. Content validity was established by literature review and through expert evaluation. Construct validity was supported through factor analysis that confirmed the six dimensional configuration of health-promoting lifestyle by convergence of the Personal Lifestyle Questionnaire ($r=.678$) and non-significant correlation with social desirability. Criterion related validity was demonstrated by significant correlations with concurrent measures of perceived health status and quality of life ($r=.269$ to .491). Internal consistency of the total scale equaled 0.943. Alpha coefficients for the subscales ranged from 0.793 to 0.872. Test-retest stability of the total scale equaled 0.892.
Pilot Test

A pilot study was done to test time involvement, question clarity, participant understanding and adequacy of instructions related to the questionnaires, and reliability of the questionnaires. Ten patients at a northeastern Wisconsin free clinic were surveyed. The pilot test was conducted Monday through Thursday for 2 weeks. Pilot testing data was retained and incorporated into the final sample to increase the sample size.

Data Collection Procedures

A northeastern Wisconsin free clinic was identified as having a large population of multiethnic uninsured adults. Verbal and written permission to use this site was obtained per the site director, Leona Whitman. Instructional Review Board approval was obtained and data collection followed. Sampling goal was 50 participants. Participants were provided a pen, clipboard, and questionnaires by reception staff and were asked to voluntarily complete the questionnaire upon check-in at the reception desk in the waiting room of the clinic. Reception staff were provided with a scripted document that they used with each individual they approached to participate in the study (Appendix F). After checking the patient in for their appointment, the receptionist used the script to ask the patient if they would be willing to participate. They were asked to complete the questionnaire while they waited for their provider or after their visit was complete. The participants were asked to deposit the questionnaire into a sealed box at the reception desk before they left the clinic. Questionnaires were distributed to participants Monday through Thursday for 2 months. The clinic is not open on Fridays or on weekends.
Protection of Human Subjects

Approval was received from the IRB at the University of Wisconsin-Oshkosh (Appendix A). Participants were asked for voluntary participation. They were instructed not to write their name on the questionnaire. Informed consent was attached to the questionnaire (Appendix G) and informed the participant that by completing and returning the questionnaire they have indicated their consent. The informed consent stated that participation was voluntary and that no penalties would be imposed upon the participant for not participating nor did it affect their medical care. The researcher was not present to administer the questionnaire.

Questionnaires were placed in an enclosed container by the participant upon completion. Staff members were instructed to hold the enclosed container for the participants to deposit their questionnaire upon completion. This ensured that the participant is the only one handling the questionnaire. Questionnaires were collected weekly and were kept in the researcher’s home office in a locked file box. These steps helped to maintain confidentiality and anonymity.

Data Analysis Procedures

Data was analyzed per descriptive and inferential statistics. Descriptive statistics were used to analyze frequencies and percentages in regard to demographics. Inferential statistics, such as Pearson’s r and t-testing, were used to determine if a relationship exists between social support, demographic characteristics, and health-promoting lifestyle behaviors. Relationships among demographics, such as age, gender, and income were analyzed in regard to social support and health-promoting lifestyle behaviors. A 95% confidence interval was used.
Anticipated Limitations

Geographic limitations and utilization of a convenience sample may restrict the generalizability of the results. Also, the reliability of self-report information and response bias could limit the validity of the results.

Summary

The purpose of this study was to explore if a relationship exists between social support and health-promoting lifestyle behaviors in uninsured adults, as well as relationships between select demographic characteristics, such as age, gender, marital status, income, and educational level. In this chapter, population, sampling method, data collection, and data analysis techniques were discussed. Possible limitations of the study were also addressed.
CHAPTER IV
RESULTS AND DISCUSSION

Introduction

The purpose of this study was to investigate if there is a relationship between social support and health-promoting lifestyle behaviors in uninsured adults, as well as relationships between select demographic characteristics and each of the variables. The research questions were:

1. Is there a relationship between social support and health-promoting lifestyle behaviors in uninsured adults?
2. Is there a relationship between social support and select demographic characteristics of uninsured adults?
3. Is there a relationship between health-promoting lifestyle behaviors and select demographic characteristics in uninsured adults?

The researcher presents the results of the study as related to these research questions. Demographic data and statistical tabulation of data are presented in this chapter.

Accessing the Sample

The target population was multiethnic, English-speaking, uninsured adults, aged 18 to 64 years. The accessible population was multiethnic, English-speaking, uninsured adults 18 to 64 years of age who utilize a northeastern Wisconsin free clinic.
Description of Pilot Study Sample

A pilot study was conducted to test ease of questionnaire distribution, time involvement, question clarity, participant understanding and adequacy of instructions related to completion of the questionnaires, adequacy of the incentive, and why a participant may refuse to complete the questionnaire. Fifteen questionnaires were given to the reception staff a northeastern Wisconsin free clinic for random distribution to clients meeting the eligibility criteria at the clinic. Participants filled out the questionnaires in the waiting room of the clinic before their appointments. Pilot testing began December 7, 2009 and ended December 17, 2009. Pilot testing returned 15 questionnaires in the 8-day test period. Reception staff reported that there were no problems with distribution or complaints from participants about the questionnaires. Completing the questionnaires took approximately 5 to 10 minutes, as predicted. Staff found that if clients refused participation in the study, it was because they could not read English well or because they were in a hurry and felt they did not have enough time to complete the survey. They also found that many people chose to participate without wanting to take the incentive fruit or granola bar. The researcher chose to proceed with the final study, as the survey goal of 10 was exceeded and staff felt that the process of approaching and surveying patients was easy and less time consuming than they thought it may be.

Final Study Demographic Data

At the beginning of the study, reception staff were given 60 questionnaires to distribute to clients. The final study yielded a sample size of \( n = 52 \). Pilot study participants were included in the final sample data to increase sample size.
Gender was distributed evenly in the study, as half of the participants \((n = 26)\) were female. In regard to age, 34\% of the participants were between the ages of 51 and 64, followed by those ages 41 to 50 at 30.8\%, then those ages 30 to 40 at 19.2\%, and lastly, those ages 18 to 29 were 15.4\% of the sample. Data regarding gender and age are represented in Table 1.

Table 1

*Demographic Data – Gender and Age \((n = 52)\)*

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>26</td>
<td>50.0</td>
</tr>
<tr>
<td>Female</td>
<td>26</td>
<td>50.0</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 – 29</td>
<td>8</td>
<td>15.4</td>
</tr>
<tr>
<td>30 – 40</td>
<td>10</td>
<td>19.2</td>
</tr>
<tr>
<td>41 – 51</td>
<td>16</td>
<td>30.8</td>
</tr>
<tr>
<td>51 – 64</td>
<td>18</td>
<td>34.6</td>
</tr>
</tbody>
</table>

The majority of the study sample was White at 82.7\%. African Americans comprised 13.5\%, Asians 1.9\%, and Hispanics 1.9\%. Most individuals were not married (38.5\%). Data regarding race and marital status are represented in Table 2.
Table 2

Demographic Data – Race and Marital Status (n = 52)

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>43</td>
<td>82.7</td>
</tr>
<tr>
<td>African American</td>
<td>7</td>
<td>13.5</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1</td>
<td>1.9</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>1.9</td>
</tr>
<tr>
<td>American Indian</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>16</td>
<td>30.8</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td>1.9</td>
</tr>
<tr>
<td>Divorced</td>
<td>13</td>
<td>25.0</td>
</tr>
<tr>
<td>Never Married</td>
<td>20</td>
<td>38.5</td>
</tr>
<tr>
<td>With Partner</td>
<td>2</td>
<td>3.8</td>
</tr>
</tbody>
</table>

A majority of the sample, 61.5%, had completed at least high school level education. Approximately 63.5% of the population report that their income falls within the range of $0 to $20,000. Data regarding education level and total household income is represented in Table 3.

Table 3

Demographic Data – Education and Income (n = 52)

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education Level Completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>6</td>
<td>11.5</td>
</tr>
<tr>
<td>High school</td>
<td>32</td>
<td>61.5</td>
</tr>
<tr>
<td>GED / HSED</td>
<td>4</td>
<td>7.7</td>
</tr>
<tr>
<td>College</td>
<td>8</td>
<td>15.4</td>
</tr>
<tr>
<td>Advanced degree</td>
<td>2</td>
<td>3.8</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - $20,000</td>
<td>33</td>
<td>63.5</td>
</tr>
<tr>
<td>$21,000 - $30,000</td>
<td>11</td>
<td>21.2</td>
</tr>
<tr>
<td>$31,000 - $40,000</td>
<td>6</td>
<td>11.5</td>
</tr>
<tr>
<td>$41,000 - $50,000</td>
<td>1</td>
<td>1.9</td>
</tr>
<tr>
<td>$50,000 or greater</td>
<td>1</td>
<td>1.9</td>
</tr>
</tbody>
</table>
Research Questions

Research Question 1: Is there a relationship between social support and health-promoting lifestyle behaviors in uninsured adults? Mean scores for the DUFSS and HPLPII were calculated to represent the overall perceived social support and engagement in health-promoting lifestyle behaviors respectively. The results of the DUFSS revealed a mean score of 3.66 (SD = 1.08), which corresponds with a moderate score, which represents “some” perceived social support but respondent “would like more.” The HPLPII revealed a mean score of 2.39 (SD = 0.48), indicating that the population “sometimes” engages in the behaviors surveyed on the questionnaire, such as getting enough sleep, eating two to four servings of fruit per day, and asking health professionals for information about how to take good care of myself. A Pearson correlation was performed and revealed a moderate positive relationship between the DUFSS and HPLPII means $r = 0.576$ and $p < 0.05$, and is represented in Table 4 (Salkind, 2000). This finding is consistent with other published studies. Adams et al., (2000); Allen et al., (2008); Beal et al., (2009); Boutin-Fosterm (2005); and Jackson (2006) all have performed research that support the positive relationship between social support and health-promoting behaviors. There are many conceivable explanations for this relationship. An individual’s past experiences, such as high levels of social support and success in achieving health-promoting behaviors, may increase perceptions of self-efficacy and increase motivation. Alternatively, having low levels of social support and not successfully attaining health-promoting behaviors may reinforce lack of participation in health promotion behaviors. Interpersonal influences, such as lack of support networks or negative social support influences, can adversely influence health-promoting behaviors. Individuals may lack feedback, motivation, encouragement, and
reinforcement from those around them to aid in achieving goals. In the uninsured population, lack of social support related to poor availability of providers, poor access to healthcare facilities, or infrequent use of healthcare providers may negatively affect health-promoting behaviors.

Table 4

*Pearson Product-Moment Correlations Between Measures of Perceived Social Support (DUFSS) and Health-Promoting Lifestyle Behaviors (HPLPII)*

<table>
<thead>
<tr>
<th>Scale</th>
<th>DUFSS</th>
<th>HPLPII</th>
</tr>
</thead>
<tbody>
<tr>
<td>DUFSS</td>
<td>--</td>
<td>0.576**</td>
</tr>
<tr>
<td>HPLPII</td>
<td>0.576**</td>
<td>--</td>
</tr>
</tbody>
</table>

** p<0.05 (2 tailed)

Research Questions 2: Is there a relationship between social support and select demographic characteristics of uninsured adults? One significant relationship was discovered between social support and race. Due to the unequal distribution of sampling, race was recoded into White and non-White participants. A paired-samples t-test was conducted with the recoded data and resulted in a significant decrease in non-White DUFSS means scores (M = 2.73, SD = 1.48) versus White (M = 3.82, SD = 0.96), t (48) = 2.57, p<0.05 (two-tailed). The mean difference between the non-White and White DUFSS scores was 1.08, with a 95% confidence interval ranging from 0.24 to 1.93.

When analyzing the original group statistics data stratified by individual races (White, African American, Hispanic, Asian and American Indian), the highest average DUFSS score of 4.75 belonged to one Hispanic participant, followed by 3.82 (SD = 0.96).
for Caucasians and 2.75 (SD = 1.48) and 2.73 for African Americans and one Asian participant, respectively. There were no American Indians surveyed.

Females, on average, scored higher than males on the social support questionnaire. Females mean score was 4.01 (SD = 0.88) versus the average male score of 3.33 (SD = 1.19). This suggests that women felt that in regard to social support, they have on average “almost as much as I would like” compared to men, who on average, felt they had “some, but would like more.” The mean DUFSS score was highest among those ages 51 to 64 years, at 3.97(SD = 0.88). This suggests that these individuals have some sources of social support, but feel like they could use more. All other categories scored between 3.32 and 3.76, suggesting about the same result. Two individuals with partners reported a mean of 4.38 (SD = 0.88). Those individuals never married, divorced, and married all reported scores between 3.39 and 3.90. No significant relationship was found via the ANOVA t-test. Most individuals in the study completed a high school education level. Those high school graduates averaged 3.73 (SD = 0.96) in regard to social support, similarly to those college graduates. Those with advanced degrees and GED/HSED scored the highest in regard to perceived social support at 4.56 (SD = 0.27) and 4.59 (SD = 0.41), respectively. No significant relationship was detected via ANOVA t-testing between these variables. Most (33 of 52) of the participants in this study fell into the $0 - $20,000 total household income category. The mean score of perceived social support was 3.67 (SD = 1.09). Each category of income revealed similar scores, ranging from 3.63 to 3.66. Due to the limited sample size and lack of diversity of the sample, a conclusion that higher income individuals have higher perceived social support cannot be made.
Research question 3: Is there a relationship between health-promoting lifestyle behaviors and select demographic characteristics in uninsured adults? No significant relationships between health-promoting lifestyle behaviors and demographic variables were revealed by this study.

The mean of the HPLPII between genders was similar, with males scoring an average of 2.22 (SD = 0.49) and females scoring a little higher at 2.57 (SD = 0.42). This indicates that this sample averages a score that coincides with “sometimes” engaging in health-promoting lifestyle behaviors. In regard to age, all age ranges scored means between 2.29 and 2.47. The mean score of the HPLP related to race was 2.08 to 2.73, with African Americans scoring the lowest. Marital status revealed means scores of 2.28 to 2.88. Those “with partners” scored the highest. Education level related to health-promoting lifestyle behaviors revealed similar means between 2.22 and 2.68, but no significant relationship was found. The majority of participants that fell into the $0 - $20,000 income range scored a mean 2.44 (SD = 0.47), followed by those with incomes $21,000 - $30,000 at 2.33 (SD = 0.57).

Discussion

The mean score (3.66) of the DUFSS corresponds with a moderate score, indicating “some” perceived social support, but participants “would like more.” The HPLPII mean score (2.39) indicates that the population “sometimes” engages in the health-promoting lifestyle behaviors surveyed on the questionnaire. A statistically significant relationship was found between perceived social support and health-promoting lifestyle behaviors and between race and perceived social support. There were no statically significant relationships found between social support nor health-
promoting behaviors among the remaining demographic characteristics. These important findings indicate that this uninsured population of people, on average, may lack perceived social support and would prefer to have more. It also indicates that this population also lacks important health-promoting lifestyle behaviors. Due to the unequal distribution between White and non-White participants, data were recoded to include all minority races as non-Caucasian and Whites as Caucasian. After recalculating, t-testing results were consistent with a significant relationship.

Most participants surveyed in this study were over 40 years of age and almost equally distributed between genders. A majority of those participants with incomes $0 - $20,000 were also over 40 years of age, white, and divorced or never married, suggesting that there may be an association with lower income, marital status, and race in these uninsured individuals. However, given the small and poorly diversified sample, these associations are difficult to make.

Considering all of these findings, social support may be an important factor influencing why people participate in health-promoting behaviors. Social support appraisal needs to be utilized in primary care in order to promote participation in health-promoting behaviors in individuals. When assessing social support, it may be important to assess not only perceived support, but also the perceived number of contacts within the individual’s social network. This study also indicates race may be an important factor for health professionals to consider when assessing perceived social support and trying to individualize care for patients.
Summary

In this chapter the results and discussion were presented. Descriptive statistics were used to determine frequencies of data. Pearson's $r$ was used to analyze the relationship between social support and health-promoting behaviors. T-testing was used to analyze the variance of means between demographic groups in relation to social support and health-promoting lifestyle behaviors. A statistically significant relationship was found between perceived social support and health-promoting lifestyle behaviors and between race and perceived social support. There were no statically significant relationships found between social support or health-promoting behaviors among the remaining demographic characteristics.
CHAPTE}\v
SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

In this chapter, a summary of the study and conclusions derived from study data are presented. Conclusions and implications for future nursing practice, education, and research are discussed.

Study Summary

The purpose of this study was to investigate if there is a relationship between social support and health-promoting lifestyle behaviors in uninsured adults, as well as relationships between select demographic characteristics and each of the variables. The research questions were:

1. Is there a relationship between social support and health-promoting lifestyle behaviors in uninsured adults?
2. Is there a relationship between social support and select demographic characteristics of uninsured adults?
3. Is there a relationship between health-promoting lifestyle behaviors and select demographic characteristics in uninsured adults?

Pender’s Revised Health Promotion Model (Figure 1) provided the framework for this descriptive correlational study. Use of this model helped to identify the interrelatedness of cognitive, personal, interpersonal, situational, and behavioral factors, as well as previous behaviors and their affect on health promotion is essential to primary
care nursing in order to promote effective nursing interventions and improve health-promoting behavior outcomes in patients.

A six-item demographic survey developed by the researcher was used to identify demographic factors. The Duke-UNC Functional Social Support questionnaire developed by Broadhead et al. (1988) was administered to assess perceived social support. The 52-item, Health Promotion Lifestyle Profile II developed by Walker & Hill-Polerecky (1996) was used to assess the frequency of self-reported health-promoting behaviors in the areas of health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management.

There were a total of 52 participants, comprised of 26 males and 26 females, convenience sampled from a northeastern Wisconsin free clinic. After obtaining Human Subjects Committee approval, data for this study was collected prior to or after a patient’s visit with a provider at a northeastern Wisconsin free clinic. Descriptive statistics were used to determine frequencies of data. Pearson’s r was used to analyze the relationship between social support and health-promoting behaviors. T-testing was used to analyze the variance of means between demographic groups in relation to social support and health-promoting lifestyle behaviors.

A statistically significant relationship was found between perceived social support and health-promoting lifestyle behaviors and between race and perceived social support. There were no statically significant relationships found between social support nor health-promoting behaviors among the remaining demographic characteristics.
Conclusions

Based on the findings of the study, the following conclusions were reached:

1. There is a moderately significant relationship between perceived social support and health-promoting lifestyle behaviors in uninsured adults.
2. There is a significant relationship between social support and race in uninsured adults.
3. There are no significant relationships between social support and select demographic factors, such as gender, age, income, education level, and marital status.
4. There are no significant relationships between health-promoting lifestyle behaviors and select demographic factors, such as gender, age, race, income, education level, and marital status.

Limitations

Study limitations include:

1. The study was limited by convenience sampling versus random sampling.
2. The study sample was small and not ethnically diverse.
3. The study sample was limited to those who could read English.
4. The study sample was obtained at a free clinic in a county of predominantly White individuals.
5. The study sample was obtained at a free clinic that the uninsured participants are utilizing for free health services versus sampling uninsured people who have no access to free health services.
6. The study lacked additional demographic variables regarding living arrangements, employment status, or why participants do not have insurance benefits.

7. The study may have an element of bias, as study participants were chosen per reception staff who worked at the clinic.

Implications for the Advanced Practice Nurse

The major implication in this study is the role of the Advanced Practice Nurse (APN) in assessing perceived social support and social networks of an individual in order to promote health-promoting lifestyle behaviors, help individuals overcome barriers to participating in healthy behaviors, and to help them enhance social networks or increase perceived social support if it is lacking. It is also essential for the APN to take into consideration demographic factors that may affect patients’ abilities to access healthcare, understand the importance of routine healthcare, and participate in healthy behaviors. It is essential for advanced nursing practice to focus on factors that influence health-promoting behaviors in efforts to combat chronic illness. In primary care, advanced practice nurses are responsible for educating patients and families about health promotion and healthy lifestyle behaviors and motivating patients to engage in these behaviors. It is essential that primary care practitioners understand how influences, such as social support and demographic characteristics, can affect these behaviors. Advance practice nurses may then individualize care of their patients in regard to these influences.
Implications for Education

Another major implication of this study is the role education plays in assessment of perceived social support. Assessment of social support is critical to nursing as a practice. Assessment of social support must be a part of nursing curriculum, whether bachelor’s prepared or master’s prepared, in order to promote holistic and comprehensive care of the patient. Because significant relationships between social support, health-promoting behaviors, and mortality have been proven, it is essential that assessment of this important variable be taught in nursing curriculum in order to combat the rising costs of healthcare and prevent the devastating effects of chronic illness. Assessment of perceived social support can provide nurses information to help guide and individualize the plan of care to include collaborative measures to promote or enhance social support to prevent chronic illness, minimize cost, and decrease mortality.

Implications for Research

While much study has been done on how social support influences health and mortality, it has not been addressed much in the uninsured population. Assessing if and how social support influences health-promoting behaviors in uninsured people is essential to promoting individual and community health. Successful studies could help to influence funding for programs targeting the uninsured population to enhance social support. While this study determined that there is significant relationship between social support and health-promoting lifestyle behaviors and race, the study’s sample was small and not diverse enough to be generalizable to the population. Further, research studies with large, diverse samples of uninsured individuals should assess social networks and
perceived social support, while also assessing the influence demographic variables may have on social support.

Recommendations

The following are recommendations for future research:

1. Replicate and repeat the study using a larger sample size that represents a more culturally diverse group, and uninsured people in communities who do not have access to free health services, would provide for more generalizable results regarding the relationships between demographic variables and social support and health-promoting lifestyle behaviors in uninsured adults.

2. Repeat the study with a social support tool that allows individuals to identify how many individuals they feel that they have in their social network that they can utilize for social support.

3. Repeat the study using additional demographic variables, such as living arrangements, employment status, or why they do not have insurance benefits, as these may be issues in this population that may affect not only perceived social support, but the number of those available to support the individual as well as their access to healthcare facilities and consistency of care.

4. Repeat the study and provide surveys in other languages to access a more diverse population.
5. Repeat the study and have a non-biased individual trained to survey individuals to conduct the surveying versus reception staff of the clinic, as this may have affected the number of those surveyed. Reception staff may have preconceived notions of who may or may not participate based on their knowledge of the individual that might have affected why they did or did not survey them, biasing the results.

Summary

In this chapter, a summary of the research study was given. Conclusions of the study findings, implications for future nursing practice and recommendations for future research were discussed. This study sought to determine if a relationship existed between perceived social support and health-promoting lifestyle behaviors in uninsured adults, as well as if relationships exist between certain demographic factors and social support and health-promoting lifestyle behaviors. Results indicate that there is a significant relationship between perceived social support and health-promoting lifestyle behaviors in uninsured individuals. The results of the DUFSS revealed mean perceived support scores that represent that the population has some perceived social support, but would like more. The HPLPII revealed a mean health-promoting lifestyle score that indicated that the population sometimes engages in health-promoting behaviors. There was also a significant relationship discovered between perceived social support in Caucasian uninsured individuals and non-Caucasian uninsured individuals. Caucasian uninsured individuals appear to have higher perceived social support than those non-Caucasian uninsured participants.
The results of this study will add to an APN’s knowledge that a relationship does exist between social support and health-promoting lifestyle behaviors, specifically in uninsured adults, and support other studies finding that this relationship exists in other populations, as well. Advanced practice nurses can use this knowledge to better assess social support, social support networks, and demographic factors in order to provide more competent and individualized care for their patients.
APPENDIX A

Institutional Review Board Approval Letter
Ms. Kasey Coey-Boerner

Dear Ms. Coey-Boerner:

On behalf of the UW Oshkosh Institutional Review Board for Protection of Human Participants (IRB), I am pleased to inform you that your application has been approved for the following research: The Relationship Between Social Support and Health Promoting Lifestyle Behaviors of Uninsured Adults.

Your research has been categorized as EXEMPT. This means you will not be required to obtain signed consent. However, unless your research involves only the collection or study of existing data, documents, or records, you must provide each participant with a summary of your research that contains all of the elements of an Informed Consent document, as described in the IRB application material. Permitting the participant, or parent/legal representative, to make a fully informed decision to participate in a research activity avoids potentially inequitable or coercive conditions of human participation and assures the voluntary nature of participant involvement.

Please note that it is the principal investigator’s responsibility to promptly report to the IRB Committee any changes in the research project, whether these changes occur prior to undertaking, or during the research. In addition, if harm or discomfort to anyone becomes apparent during the research, the principal investigator must contact the IRB Committee Chairperson. Harm or discomfort includes, but is not limited to, adverse reactions to psychology experiments, biologics, radioisotopes, labeled drugs, or to medical or other devices used. Please contact me if you have any questions (PH# 920/424-7172 or e-mail: rauscher@uwosh.edu).

Sincerely,

[Signature]

Dr. Frances Rauscher
IRB Chair

cc: Dr. Judith Westphal
1689

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APPENDIX B

Living Healthy Community Clinic Permission Letter
October 27, 2009

To Whom It May Concern:

Kasey Coey-Boerner has my permission to utilize our clinic population to further research in the field of nursing. Participation will be on a volunteer basis with the clients of LHCC. She has requested utilizing a survey to gather this information. If you have any further questions, please feel free to contact me at 920-424-1242.

Sincerely

[Signature]

Leonia Whitman, MPA
Living Healthy Community Clinic
510 Doctors Ct
Oshkosh, WI 54901
APPENDIX C

Demographic Questionnaire
Demographic Questionnaire

These questions will help us to collect information but will not identify you in any way.

Please circle the category that applies to you in each section.

1. Gender: Male Female

2. What is your age group?
   18 – 29  30 – 40  41 – 50  51 – 64

3. What is your race/ethnicity? (circle one)
   White African American Hispanic Asian American Indian

4. Current Marital Status (circle one)
   Married Widowed Divorced Never Married With Partner

5. What is the highest grade you completed in school? (circle one)
   Less than high school  High school graduate
   Advanced Degree (Master’s, PhD)  GED/HSED  College

6. What is your income group? (circle one)
   $0 - $20,000  $31,000 - $40,000  $50,000 and greater
   $21,000 - $30,000  $41,000 - $50,000

Thank you for helping with this study. Please answer the next set of questions.
APPENDIX D

Duke UNC Functional Social Support Questionnaire
### Duke UNC Functional Social Support Questionnaire

<table>
<thead>
<tr>
<th>1. I have people who care what happens to me.</th>
<th>As much as I would like (5)</th>
<th>Almost as much as I would like (4)</th>
<th>Some, but I would like more (3)</th>
<th>Less than I would like (2)</th>
<th>Much less than I would like (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. I get love and affection.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3. I get chances to talk to someone about problems at work or with my housework.</td>
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<tr>
<td>4. I get chances to talk to someone I trust about my personal and family problems.</td>
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<tr>
<td>5. I get chances to talk about money matters.</td>
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<tr>
<td>6. I get invitations to go out and do things with other people.</td>
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<tr>
<td>7. I get useful advice about important things in life.</td>
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<tr>
<td>8. I get help when I am sick in bed.</td>
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</table>

Here is a list of some things that other people do for us or give us that may be helpful or supportive. Please read each statement carefully and place an 'X' in the column that is closest to your situation. Please give only 1 answer per row.
APPENDIX E

Lifestyle Profile II
LIFESTYLE PROFILE II

Directions: This questionnaire contains statements about your present way of life or personal habits. Please respond to each item as accurately as possible, and try not to skip any item. Indicate the frequency with which you engage in each behavior by circling.

<p>| | | | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>N</td>
<td>S</td>
<td>O</td>
<td>R</td>
</tr>
</tbody>
</table>

1. Discuss my problems and concerns with people close to me.  
2. Choose a diet low in fat, saturate fat, and cholesterol.  
3. Report any unusual signs or symptoms to a physician or other health professional.  
4. Follow a planned exercise program.  
5. Get enough sleep.  
6. Feel I am growing and changing in positive ways.  
7. Praise other people easily for their achievements.  
8. Limit use of sugars and food containing sugar (sweets).  
9. Read or watch TV programs about improving my health.  
10. Exercise vigorously for 20 or more minutes at least three times a week (such as brisk walking, bicycling, aerobic dancing, using a stair climber).  
11. Take some time for relaxation each day.  
12. Believe that my life has purpose.  
13. Maintain meaningful and fulfilling relationships with others.  
14. Eat 6 – 11 servings of bread, cereal, rice and pasta each day.  
15. Question health professionals in order to understand their instructions.  
16. Take part in light to moderate physical activity (such as sustained walking 30 – 40 minutes 5 or more times a week).  
17. Accept those things in my life which I cannot change.  
18. Look forward to the future.  
19. Spend time with close friends.  
20. Eat 2 – 4 servings of fruit each day.  
21. Get a second opinion when I question my health care provider’s advice.  
22. Take part in leisure-time (recreational) physical activities (such as
23. Concentrate on pleasant thoughts at bedtime.  
24. Feel content and at peace with myself.  
25. Find it easy to show concern, love and warmth to others.  
26. Eat 3 – 5 servings of vegetables each day.  
27. Discuss my health concerns with health professionals.  
28. Do stretching exercises at least 3 times per week.  
29. Use specific methods to control my stress.  
30. Work toward long-term goals in my life.  
31. Touch and am touched by people I care about.  
32. Eat 2 – 3 servings of milk, yogurt or cheese each day.  
33. Inspect my body at least monthly for physical changes/danger signs.  
34. Get exercise during usual daily activities (such as walking during lunch, using stairs instead of elevators, parking car away from destination and walking).  
35. Balance time between work and play.  
36. Find each day interesting and challenging.  
37. Find ways to meet my needs for intimacy.  
38. Eat only 2 – 3 servings from the meat, poultry, fish, dried beans, eggs, and nuts group each day.  
39. Ask for information from health professionals about how to take good care of myself.  
40. Check my pulse rate when exercising.  
41. Practice relaxation or meditation for 15 – 20 minutes daily.  
42. Am aware of what is important to me in life.  
43. Get support from a network of caring people.  
44. Read labels to identify nutrients, fats, and sodium content in packaged food.  
45. Attend educational programs on personal health care.  
46. Reach my target heart rate when exercising.  
47. Pace myself to prevent tiredness.  
48. Feel connected with some force greater than myself.  
49. Settle conflicts with others through discussion and compromise.  
50. Eat breakfast.  
51. Seek guidance or counseling when necessary.  
52. Expose myself to new experiences and challenges.
APPENDIX F

Scripted Instructional Document
Receptionist:

“A graduate nursing student at UW Oshkosh is doing a study about social support and health-promoting behaviors in people without insurance. We are looking for people to be in the study. If you agree to help you will need to fill out three short forms that answer questions about yourself, social support and health-promoting behaviors? You do not need to provide your name on the forms and will not be identified at any time. Being a part of this study will not affect the care you get at this clinic. If you participate you may have a granola bar or piece of fruit. Would you help with the study? “

If patient responds “yes.”

Receptionist:

“Please answer all of the questions but do not put your name anywhere on the forms. After you have answered all of the questions, please put the forms in this box before you leave. You may have a granola bar or piece of fruit when you turn in the forms. Results of the study will be hung in the waiting room when the study is complete. Thank you for helping.”

If patient responds “no.”

Receptionist:

“Okay, thank you anyway.”
APPENDIX G

Consent Form
**Consent Form**

My name is Kasey Coey-Boerner. I am a graduate nursing student at the University of Wisconsin, Oshkosh. I am doing a study to see if there is a relationship between social support and health-promoting lifestyle behaviors in adults that do not have insurance. I would appreciate your help with this study. It will help me to understand the relationship between social support and healthy behaviors and to help patients make choices about their health.

You can be part of the study if:
1. You are age 18-64.
2. You can read English.
3. You have no health insurance or government assistance for healthcare.
4. You are not mentally retarded, mentally disabled or legally incompetent.
5. You are not pregnant.
6. You are not a prisoner.

Helping with this study involves filling out a short demographic form, an 8-item social support form and a 52-item health promotion lifestyle form. This should take you about 15 minutes to fill out.

**Please do not write your name on any of the forms.**

Being in this study is voluntary. Your provider will not know if you are or are not helping with the study. It will in no way affect the care you receive at the clinic. You may stop your participation at any time. The information that you share on the forms will not be linked to you in any way or put in your medical record.

Once the study is finished, I will hang a poster with the results at the clinic so that you may look at them there. If you have any questions, please feel free to contact me at (920) 410-4718.

If you have any complaints about your treatment as a participant in this study, please call or write:
Chair, Institutional Review Board For Protection of Human Participants
c/o Grants Office
UW Oshkosh
Oshkosh, WI 54901
920/424-3215

**Filling out the forms and putting them in the box at the reception desk means that you have given your consent to be in this study.**

I have received an explanation of the study and agree to be in the study. I know that being in this study is voluntary and that I may stop my participation at any time. By filling out the three forms I am giving my informed consent.

Thank you for your help.
Kasey Coey-Boerner, RN, BSN

This research project has been approved by the University of Wisconsin Oshkosh Institutional Review Board for Protection of Human Participants for a 1-year period, valid until (one year from the approval date).
REFERENCES


Hadley, J. (2003). Sicker and Poorer --the consequences of being uninsured: A review of the research on the relationship between health insurance, medical care, health, work, and income. *Medical Care Research and Review, 60*, 3S-75S.


from http://www.rwjf.org/pr/product.jsp?id=14906


The University of Nebraska Medical Center, College of Nursing. (2007, September 11). *Health Promoting Lifestyle Profile II*. Retrieved July 14, 2009, from University of Nebraska Medical Center, College of Nursing Web Site: http://app1.unmc.edu/nursing/conweb/view_content.cfm?lev1=facstf&lev2=fac&lev3=fawalker&PubStat=(none)&Web=pub
