Perceived Adequacy of Tangible Social Support and Health Outcomes in Patients with Coronary Artery Disease

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OBJECTIVE: Health outcomes of patients with chronic disease might be influenced by assistance from others in performing daily activities. We examined whether perceived adequacy of such tangible support was associated with prognosis in a cohort of patients with coronary artery disease.

DESIGN: Longitudinal cohort study.

SETTING/PARTICIPANTS: In spring 1993, a cohort of 1,468 patients with chronic artery disease was identified using claims data. The cohort consisted of all surviving residents of Manitoba, Canada, who had been hospitalized for acute myocardial infarction from 1991 to 1992: 820 patients completed the initial survey, and 734 completed a follow-up survey approximately 1 year later.

MEASUREMENTS AND MAIN RESULTS: Adequacy of tangible support was assessed by asking if respondents needed help at home because of health problems, and whether these needs were met. We examined the association between perceived adequacy of tangible support and health outcomes at 1 year (mortality, physical function). Of 820 participants, 74% perceived no need for help, 13% had sufficient help, 9% needed more help, and 5% needed much more help; 31 patients died during follow-up. After adjustment for age and initial health status, odds ratios (95% confidence interval) for death were: sufficient help 1.8 (0.61, 5.8); need more help 3.2 (1.1, 9.4); and need much more help 6.5 (2.0, 21.6) compared with respondents with no perceived need. Decline in physical function was also linearly related to perceiving less-adequate tangible support. Sensitivity analyses indicated it is highly improbable that results were due to selection bias.

CONCLUSIONS: Perceived lack of needed assistance was related to mortality and to decline in physical functioning. Adequacy of tangible support was an important prognostic factor for these patients with coronary artery disease and may be a determinant of health outcomes.

KEY WORDS: chronic disease; support; functional status; health outcomes; coronary heart disease.

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Inadequate social support is associated with poor health outcomes. Although best studied in the context of heart disease,¹⁻¹³ the importance of adequate social support has been demonstrated in a variety of conditions,¹⁴⁻²⁰ and in studies of general population health.^{21,22} In patients with known coronary artery disease, inadequate social support has been strongly linked to both fatal and nonfatal outcomes.¹⁻¹³

There are many ways to conceptualize social support. The earliest prospective studies of social support and health

outcomes focused on structural aspects (e.g., marital status, social network size,^{21,22}) but recent work has emphasized the role of social relationships^{7,10,23} and emotional support (e.g., feeling loved or supported, having a confidant).^{7,10,24} Little work has related health outcomes to a more tangible support function—help with daily tasks.

Given the functional impairments common in chronic disease,²⁵ assistance from others in performing daily activities such as bathing or taking medications may be particularly important. Because of the possibility of intervention, we examined the association between perceived adequacy of tangible support on mortality and change in functional health status in patients living with chronic coronary artery disease. Specifically, because our interest was in the relation between support and functional status among persons with chronic disease, we purposefully identified patients who had been hospitalized for, and survived, an acute myocardial infarction several months earlier.

METHODS

Study Sample

Eligible patients consisted of 1,468 Manitoba residents with known coronary artery disease. Membership in the cohort was defined by a previous hospitalization for acute myocardial infarction. Of these, 820 (56%) who agreed to participate and completed the baseline survey are the subjects for the mortality analysis.

Survey participants were interviewed during the spring of 1993 (8-22 months after the acute myocardial infarction hospitalization), and again about 1 year later. In both the initial and follow-up surveys, patients were asked to participate in a 30- to 40-minute standardized telephone interview (in the home if necessary) by trained interviewers that covered their use of medical services and medications, functional status, disease-specific symp-

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toms, and social supports. At 1 year of follow-up, 675 respondents had complete data for the functional status analysis (31 had died, 55 were lost to follow-up, and 59 had missing data).

Measures

Tangible Support. Perceived adequacy of tangible support was assessed using the following two questions. Subjects were first asked, "In the last 6 months, have you needed any kind of extra help at home because your health kept you from taking care of yourself or doing what you usually do?" If the response was "yes," they were then asked, "Of the help you got at home . . . would you say you got: all you needed, most you needed, some you needed, only a little, or none that you needed?" Responses were collapsed into four categories: (1) no perceived need for help; (2) got sufficient help (needed help, but all needs met); (3) more help needed (most needs for help met); and (4) much more help needed (only some, little, or none of needs for help met).

Respondents were also asked other questions to characterize their tangible support, such as the source of the help they received (e.g., from friends, relatives, or an agency), and whether the helper had to take off time from work. Five questions helped to assess the construct validity of our central measure. Respondents were asked how many people they could count on to provide help (help network size), whether they thought that tangible help would be available if needed, their marital status, the number of people in their household, and if they had a confidant.

Outcome Variables. *Death.* Vital status at follow-up was ascertained for all participants through Manitoba Health Services Commission files.²⁶

Physical function was assessed using the Physical Component Summary (PCS) score derived from the Medical Outcomes Study Short Form 36 (SF-36).^{25,27–29} The PCS score ranges from 0 to 100. Lower scores indicate worse health: an otherwise healthy person who developed diabetes would experience about a 3-point decline in PCS score; the decline associated with new congestive heart failure is about 7 points.²⁵

Covariates. *Mental health* was assessed using the Mental Component Summary (MCS) score derived from the SF-36.^{27,29}

Cardiac symptom assessment was assessed using a modified Canadian cardiovascular classification scale (angina)³⁰ and the Rose questionnaire (dyspnea).³¹

Sociodemographic variables included age, educational attainment, and household income (above or below 200% of the Canadian poverty level).

Other aspects of social support included structural supports (i.e., living alone or with others, marital status) and the existence of emotional support (defined as having a confidant).

Statistical Analysis

Perceived Adequacy of Tangible Support and Mortality.

We used multiple logistic regression to predict mortality across the four levels of adequacy of tangible support. To avoid overfit, we restricted ourselves to four covariates and examined the stability of the coefficients in different model specifications. The coefficients for tangible support were stable under all specifications of the model. The four variables having the strongest univariate relation to death (dyspnea, PCS score, MCS score, and age) were included in the model. Other variables (income, gender, angina, marital status, living alone, and social network size) were added one at a time to the 4-covariate model. None was independently significant, nor did any appreciably change the coefficients for the tangible support terms. Adequacy of model fit was confirmed using the Lemeshow-Hosmer test, and model discrimination was assessed by calculating the area under the receiver operating characteristic (ROC) curve. All analyses were done using STATA (College Station, Tex.).

Perceived Adequacy of Tangible Support and Physical Function.

We used multiple linear regression to model the change in physical function (PCS score) from baseline to follow-up. As this model was not constrained by the limited number of deaths, we were able to determine the relation between functional status at follow-up and the level of adequacy of tangible support after controlling for all our baseline variables: physical and mental functioning, baseline angina and dyspnea, age, gender, education, income, and other social supports. Age, PCS score, and MCS score were continuous variables in the model. Results were unchanged specifying these variables as categories.

Because there is controversy about how to assess change in functional outcomes over time when study participant deaths are unequally distributed across the exposure of interest,³² we assessed three strategies. First, we assigned death a follow-up PCS score equal to the lowest actual observed score (i.e., death was no worse than the worst outcome experienced by any survivor). Second, we examined giving no weight to death (excluding deaths from analysis), an option that is difficult to justify, and third, we examined giving death the maximum weight (assigning death a score of 0—the lowest possible value). All yielded the same general result.

RESULTS

Baseline Characteristics of Tangible Support Groups

Of the 820 patients who completed the initial survey, 74% ($n = 602$) had no perceived need for help, 13% ($n = 110$) got sufficient help, 9% ($n = 71$) needed more help, and 5% ($n = 37$) needed much more help. Perceiving less-adequate support was more common with greater age and among women and individuals with low income (Table 1).

Table 1. Baseline Characteristics of Cohort by Perceived Adequacy of Tangible Support

Characteristic	No Perceived Need n = 602 (74%)	Got Sufficient Help n = 110 (13%)	More Help Needed n = 71 (9%)	Much More Help Needed n = 37 (5%)	p Value
Demographics					
Mean age $\pm$ SD, yr	65 $\pm$ 9.9	71 $\pm$ 9.6	71 $\pm$ 8.2	69 $\pm$ 10.2	<.001
Female, %	29	46	62	57	<.001
Education < high school, %	64	68	64	53	NS
Low income,* %	61	73	80	78	<.001
Current smoker, %	17	8	7	24	.008
Health status[†]					
General health poor or fair, %	29	57	70	73	<.001
Mean PCS score $\pm$ SD	44.7 $\pm$ 10.0	35.0 $\pm$ 9.4	32.8 $\pm$ 11	32.0 $\pm$ 11	<.001
Mean MCS score $\pm$ SD	52.6 $\pm$ 9.3	51.7 $\pm$ 10.3	47.5 $\pm$ 11	44.4 $\pm$ 12	<.001
Cardiac status[‡]					
Months since MI $\pm$ SD	16.2 $\pm$ 3.2	16.2 $\pm$ 3.2	15.7 $\pm$ 3.3	16.5 $\pm$ 3.4	NS
Angina, %					
None	63	50	46	49	.002
$\geq$ Class 2	30	41	41	51	
Dyspnea, %					
None	51	35	17	35	<.001
$\geq$ Class 2	34	51	76	59	
Construct validity for social support, %					
Single	25	39	39	49	<.001
Live alone	17	33	34	46	<.001
Lack confidant	23	27	18	35	NS
Help network size [§] $\geq$ 3	63	55	55	31	.001
Future availability of help [¶]	87	75	52	36	<.001

*Total household income (adjusted for family size and urban/rural residence) less than twice official poverty level.

[†]Scored from 0 to 100, with higher scores indicating better functioning; 50 is the median score for the U.S. population.

[‡]Angina classification based on modified Canadian Cardiovascular Society Classification and dyspnea classification based on modified Rose criteria.

[§]Based on answer to the question: "How many individuals can you count on to help in time of need?"

[¶]Based on answer to the question: "If you were very sick and could not take care of yourself at all, is there someone who could fix meals and take care of things around your house for a week?"

Less-adequate support was also associated with worse health status and cardiac status. As shown in Table 1, there was no relation between level of tangible support and median time since index acute myocardial infarction ($p = .53$).

Construct Validity of Tangible Support

Perceiving inadequate tangible support was associated with less structural social support: individuals who were single or lived alone were less likely to perceive adequate tangible support. All respondents were asked about the availability of help: (1) How many people can you "count on to provide help in time of need," and (2) "If you were very sick and could not take care of yourself at all, is there someone who could fix meals and take care of things around your house for a week?" The responses to both questions were directly related to the adequacy of tangible help, suggesting that our measure assesses available help resources and not simply need for help. The

responses to these questions support the construct validity of our tangible support measure by demonstrating a continuum of help resources across levels of tangible support from no perceived need through much more help needed.

Perceived Adequacy of Tangible Support and Health Outcomes

Thirty-one patients died during follow-up. The crude mortality rates across the four levels of tangible support (adequate to inadequate) were 1.5%, 6.4%, 12.8%, and 16.3%, a dose-response relationship that persisted in the final model (Table 2). After controlling for age, baseline PCS score, MCS score, and dyspnea, the odds of dying were greater by 6.5 times (95% CI 2.0, 21.6) for patients who needed much more help than for patients with no perceived need. The area under the ROC curve for the final model was 0.86.

Table 2. Relation Between Level of Perceived Tangible Support and Health Outcomes over 1 Year of Follow-Up

Tangible Support	Adjusted Odds Ratios of Death* (95% CI) n = 820	Adjusted Relative Decline in Physical Function† (95% CI) n = 675
No perceived need	Reference	Reference
Got sufficient help	1.8 (0.61, 5.8)	−1.3 (−3.3, 0.8)
More help needed	3.2 (1.1, 9.4)	−4.5 (−7.0, −1.9)
Much more help needed	6.5 (2.0, 21.6)	−5.7 (−9.2, −2.1)

*Odds ratios of death over 1 year of follow-up were adjusted for age (continuous), baseline PCS (continuous), baseline MCS (continuous), and any dyspnea (any vs none). Area under the ROC curve 0.86. The proportion (%) of deaths in each tangible support group were: no perceived need 9/602 (1.5%); got sufficient help 7/110 (6.4%); more help needed 9/71 (12.7%) and much more help needed 6/37 (16.2%).

†Linear regression (β) coefficients for change in PCS score over 1 year of follow-up as a function of level of tangible support adjusted for age (continuous), baseline PCS (continuous), baseline MCS (continuous), gender, angina (none, grade I, II, III), dyspnea (none, grade I, II, III), income (<200% vs ≥200% Canadian poverty level), education (<high school, high school graduate, at least some college), living alone, having a confidant. Death was assigned a follow-up PCS score equal to the lowest observed score.

Inadequacy of tangible support was also associated with worse functional outcomes over the follow-up period (Table 2). After controlling for age, income, baseline physical and mental function, angina, dyspnea, gender, education, and other social supports (living alone and having a confidant), we found a dose-response relationship between less perceived support and a decline in physical function over the follow-up period. In this model, death was assigned the lowest observed PCS score. The dose-response relationship was also observed when death was given a PCS score of 0. In the model in which death was excluded, the trends were in the right direction, but a significant dose-response relationship was not observed; the difference between the two groups needing help was not significant.

Sensitivity Analyses

In this study, nonparticipants were older (mean age 71 vs 66 years) and had a higher mortality rate than participants during follow-up (11% vs 4%). Thus, we performed a sensitivity analysis to examine the extent to which our results might be attributable to selection bias. We dichotomized the support variable into “low” support (more help needed, much more help needed) and “adequate” support (no perceived help needed, got all help needed). For the 820 participants in the study, we found the relative risk of death for patients with low support compared with those with adequate support was 6.2.

We examined three possible scenarios that varied in

what proportion of the nonparticipants were assigned to the low support group: 14% (the proportion among participants), 25%, and 50%. Within each of these scenarios, we calculated how protective low support would have to be among nonparticipants to achieve an overall relative risk less than 1.0. In each case we found that in order to eliminate the association between low support and death, low support would have to have a substantial protective effect among nonparticipants.

Specifically, if fewer than 17% of the nonparticipants were assigned to low support, even if low support was perfectly protective (i.e., no deaths among the nonparticipants with low support), the relative risk overall could not be below 1.0. With 25% of the nonrespondents assigned to the low support group, we found the risk of death for nonrespondents with low support would have to be 83% lower than that of nonrespondents with adequate support. With 50% of the nonrespondents assigned to the low support group, we found the risk of death for nonrespondents with low support would have to be 73% lower than that of nonrespondents with adequate support.

DISCUSSION

Previous investigations of the relation between tangible support and health outcomes have studied depression,^{15,16,33} osteoarthritis,²⁰ and pregnancy.¹⁹ None has examined perceived adequacy of tangible support and health outcomes in heart disease. We have demonstrated an important relation between perceived adequacy of tangible support and both mortality and functional status. Inadequate tangible support was a significant predictor of death and greater functional deterioration during the 1-year follow-up period.

We recognize several limitations to our study. First is the limited rate of recruitment into the study. Only 56% of eligible patients agreed to participate. Nonparticipation can affect the generalizability of a study. In our study, nonparticipants were older (mean age 71 vs 66 years) and had a higher mortality rate than participants during follow-up (11% vs 4%); our cohort represents a relatively healthy subset of long-term survivors of myocardial infarction. Limited recruitment, however, is a recognized problem of virtually all cohort studies: for example, the Framingham Heart Study and the Nurse's Health Study, two studies focused on the general population who presumably face fewer barriers to recruitment, have initial recruitment rates close to 70%.³⁴ More important, it is doubtful that nonparticipation affected the validity of our results. A sensitivity analysis demonstrated that the observed associations would be eliminated only if inadequate tangible support had an implausibly large protective effect among nonparticipants.

A second limitation is the possibility that missing data might bias the functional outcomes analysis. Only 14% of our cohort, however, had missing end points, and at every level of tangible support, age or PCS differences

between those with and those without complete data were negligible. Third, our information detailing tangible support is limited. Although we do know that many respondents perceived unmet tangible needs, our data do not indicate the specific needs that were unmet. Nor do we know whether such needs could be filled or whether the source of help matters. Some may be reluctant to accept help from strangers, while others may experience anxiety and guilt when dependent on family and friends.

Finally, it is possible that the need for tangible support is simply a proxy for health status. However, we utilized one of the most widely used measures of general health status, the SF-36,²⁵ as well as two other disease-specific measures (the Canadian Cardiovascular Classification System for angina,³⁰ and the Rose questionnaire for dyspnea³¹) to adjust for baseline health status. Even after adjustment, adequacy of tangible support added important prognostic information to the health status assessment.

Our data suggest, however, that adequacy of tangible support may represent more than a prognostic marker—inadequate tangible support may be an independent determinant of poor health outcomes. The strength of our findings, the evidence of a dose-response relationship, the correct time sequence (i.e., adequacy of support assessed preceded outcome assessment), and consistency with other studies relating inadequate social supports with worse health outcomes in patients with coronary heart disease,¹⁻¹³ all raise the possibility of a causal relationship.³⁴ Biologically plausible mechanisms for such a relationship include physiologic consequences of inadequate support (e.g., mental stress) or indirect mechanisms (e.g., medication compliance). Observational studies such as ours, however, cannot settle the issue of causation. Reliably determining the effect of tangible support will require a randomized clinical trial. Before a randomized trial is contemplated, however, it may be necessary to learn which forms of tangible support are most strongly associated with improved outcomes. Even in the absence of such data, our study suggests that two simple questions about the perceived adequacy of tangible support may help clinicians identify patients with chronic coronary artery disease who are at high risk of poor outcomes.

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REFLECTIONS

Marathon Day '96

I.

When the swift messenger brought news of Victory
in that famous city, his trek did not
portend the thousands wearing not only
Nike, but also Reebok, the brand, incidentally,
favored by my octogenarian grandmother
who endures a different race,
making it through another
day with nothing but nothing to
do and no one to do it with,
aided not by electric
pedometers, electrolyte
sports drinks, chartreuse Spandex, orange
wedges and New York tap water
(America's best!) but rather
by her latest antidepressant
provided she is actually
taking the medicine and not
saving it because, she tells us:
"It makes me lose my balance," which
to her seems like the larger
problem, but to my family—
fielding endless late-night phone calls:
"Could you change my kitchen light bulb"
at 3 A.M.—the greater good
seems to be achieved with still more Prozac,
sacrificing balance at the altar of sanity.

II.

When I spotted an old friend—
out of touch for years, haggard
at the 24-mile mark
just above 90th Street—
and yelled his name, first and last,
from among the variegated
swarm, he looked at me strangely,
at first a grimace,
then a quarter smile:
barely able, but then, yes,
able to acknowledge me;
I felt like Theseus's
Shade, bringing strength to the Greeks;
more likely,
I had no effect, barely
altering the tenuous
balance between fatigue
and forward momentum.
And what of my sporadic checkup
phone calls to my grandmother,
in which I punctuate her
numbing stream of endless time
full of that same fatigue and
that same forward momentum
but with no message to
deliver and nowhere to deliver it?

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