Caring: Indonesian Journal of Nursing Science
Journal homepage: https://talenta.usu.ac.id/IJNS

The Multidimensional Role of Family Members in Dietary Supervision for Hypertension Patients: A Descriptive Phenomenological Study

Wirda Faswita[1], Eqlima Elfira
[1]*Akademi Keperawatan Kesdam I/BB Binjai, Indonesia*
[2]*Medical Surgical Nursing Department Nursing, Universitas Sumatera Utara, Indonesia*
Corresponding author: wfaswita@gmail.com

ARTICLE INFO

Article history:
Received 10 February 2026
Revised 13 April 2026
Accepted 6 June 2026
Available online
https://talenta.usu.ac.id/IJNS

E-ISSN: 2685-7162

How to cite: Faswita, W., & Elfira, E. (2026). The multidimensional role of family members in dietary supervision for hypertension patients: a descriptive phenomenological study. *Caring: Indonesian Journal of Nursing Science* (IJNS), 8(1), 30–38.

ABSTRACT

Long-term dietary regulation, characterized by the reduction of sodium and fat intake along with increased fiber consumption, serves as a crucial non-pharmacological component for controlling blood pressure in patients with hypertension. Therefore, this study aims to identify and analyze the various dimensions of the family's role in dietary supervision for members suffering from hypertension. The study procedures were carried out at UPT Puskesmas Medan Sunggal (July-August 2025) using a qualitative design with a descriptive phenomenology approach. The participants (n=8) were selected using a purposive sampling method. Data from semi-structured interviews were analyzed using Colaizzi's seven-step method, involving transcription, significant statement extraction, and thematic formulation. The results showed that the family's role was divided into 3 interconnected main categories. First, the family as a practical supervisor and food environment modifier, where members actively limited the use of salt, oil, and flavor enhancers during cooking and controlled the availability of fast food at home. Second, the family as motivation and emotional coping supporter, where members provided encouragement, reminded the patient using gentle language, and helped the patient cope with the frustration associated with dietary changes. Third, as a behavior model and informal educator, where members collectively adopted healthier eating patterns (low salt), preventing the patient from feeling isolated, and proactively provided nutritional information. These results recommend the empowerment of families by the primary health center to improve communication skills and the preparation of healthy meals that are acceptable to hypertensive patients.

Keyword: Dietary Supervision, Family Members, Hypertension, Role

https://doi.org/1032734/ijns.v8i1.23765

1. Introduction

Hypertension, defined as persistently high blood pressure, remains a serious global public health concern and a key risk factor for morbidity and premature death from cardiovascular diseases, such as stroke and coronary heart disease (World Health Organization, 2023). According to Global Burden of Disease (GBD) data, there has been a consistent increase in hypertension prevalence, particularly in Indonesia. This indicates its control remains an issue, with a large number of patients unaware of their health issue or non-adherent to treatment (Ministry of Health, 2018).

According to previous studies, hypertension remains a critical global health threat, affecting 1.28 billion adults, with fewer than half achieving effective control (World Health Organization, 2021). This challenge is significant in Indonesia, where national prevalence stands at 34.1%. However, the primary concern is the low awareness and poor adherence to treatment among patients (World Health Organization, 2021). The challenge is also reflected in Indonesia, showing that the prevalence in individuals aged 18 years and older reaches 34.1%. Among these numbers, only about one-third of sufferers are aware of their status, and only a small fraction are adherent to medication and lifestyle modifications (Ministry of Health Republic Indonesia, 2018). The situation is even more evident in North Sumatra, where prevalence reaches 35.4%, surpassing the national average. This elevation is largely attributed to modern lifestyles and local dietary habits high in sodium and fat, indicating the urgent need for interventions focused on routine screening and the reinforcement of family-based dietary management (Ministry of Health, 2024)

According to previous studies, hypertension management demands a comprehensive approach, relying not only on medication (pharmacological) but also on lifestyle changes (non-pharmacological). The primary component of non-pharmacological management is dietary regulation, specifically limiting sodium (salt) intake, reducing saturated fat consumption, and increasing the intake of fiber-rich foods (Yang et al., 2022). An uncontrolled diet can trigger an increase in blood pressure. Meanwhile, adherence to the Dietary Approaches to Stop Hypertension (DASH) diet has been proven to significantly lower blood pressure in adults, both those with and without hypertension. This blood pressure-lowering effect tends to be stronger in younger people and those with higher daily sodium intake (Yang et al., 2022).

Improving long-term dietary adherence is a substantial challenge for hypertensive patients. Key barriers include the difficulty of changing established eating habits, limited nutritional knowledge, and a lack of a supportive social environment (National Heart, Lung and Blood Institute (NHLBI), 2025). The immediate social environment, especially the family, plays a central role in influencing the success of chronic disease management (Mestre, 2024). Since these dietary patterns are deeply embedded in daily domestic life, the family emerges as the primary influence on a patient's nutritional choices. Consequently, the family acts not only as a reminder but also as a central food provider and dietary environment controller. This role comprises practical functions such as ensuring meals served are low in salt and fat, as well as psychosocial functions, namely providing the emotional support and motivation necessary for long-term behavioral change (Khoirunnisa et al., 2024). Family members play a crucial role in supporting individuals with hypertension by providing emotional reassurance, encouragement, and practical assistance that enhance overall disease management. Their involvement is associated with improved adherence to prescribed medications and the adoption of healthier lifestyle practices, including reminders for medication intake and facilitating access to nutritious, low-sodium foods. Such support strengthens patients' motivation, promotes sustained behavioral change, and fosters consistency in treatment adherence (Chham et al., 2026). Evidence from Southeast Asia further indicates that strong family involvement is positively associated with dietary adherence among hypertensive patients (Cuevas et al., 2021). This relationship is particularly evident in collectivistic societies, where dietary practices extend beyond individual choice and are deeply shaped by the household environment. As the family functions as the primary regulator of food preparation and consumption, a patient's ability to maintain a low-salt diet is often influenced by shared eating patterns. Consequently, poor blood pressure control may reflect limitations within the domestic support system, especially when family practices do not align with recommended dietary modifications or continue to favor traditional high-sodium meals over clinical requirements.

The working area of UPT Puskesmas Medan Sunggal, as one of the primary health care centers in Medan City, has a considerably high population of hypertensive patients requiring intensive health monitoring. In 2023, hypertension was recorded as one of the top 10 most prevalent diseases at this facility, with 858 cases reported (Zhafira Aliefanny & Mona Hastuti, 2025). Despite the implementation of education programs by the Primary Health Center (Puskesmas), data indicate that 4 out of 5 patients still experience blood pressure fluctuations, suggesting that dietary adherence requires further improvement.

While the importance of dietary adherence in hypertension management is well-established, a critical gap persists between clinical recommendations and the daily domestic reality at UPT Puskesmas Medan Sunggal. The significant problem is the cultural and structural barriers within the household that render individual-centered education ineffective. In the North Sumatran context, traditional culinary habits heavily rely on high-sodium seasonings, making independent diet adherence nearly impossible for patients. Preliminary data at this facility reveal a troubling trend, where 4 out of 5 patients still experience significant blood pressure fluctuations despite the implementation of routine education programs. This underscores a systemic failure, namely the underutilization of the family's domestic authority in managing dietary intake.

Families in this region possess the 'power of the kitchen,' but no phenomenological study has specifically explored the complex experiences and challenges of members in supervising salt, fat, and fiber usage. The lack of family-centered strategies creates a disconnect where medical advice is often overruled by traditional eating habits. Therefore, this qualitative study is imperative to uncover the multidimensional roles and hidden challenges faced by family supervisors. By analyzing the dynamics, the current study was carried out to identify practical, culturally sensitive recommendations that can bridge the gap between clinical guidelines and sustainable family-based health interventions in 2025.

2. Methods

2.1 Study Design

This study employed a qualitative design with a descriptive phenomenological approach to explore the lived experiences and meanings attributed by family members who supervised the diets of relatives with hypertension. This approach was selected because it enables an in-depth description of participants' experiences in their natural context while minimizing the imposition of pre-existing theoretical assumptions (Creswell & Creswell, 2018).

2.2 Setting and Participants

The study was conducted from July to August 2025 in the working area of UPT Puskesmas Medan Sunggal, Medan, Indonesia. Eight family members were recruited through purposive sampling. Potential participants were identified from the health center's patient registry and medical records with assistance from the Head of UPT Puskesmas Medan Sunggal and local health cadres as gatekeepers. The inclusion criteria were: (1) being the primary family member responsible for daily dietary supervision and meal preparation for a patient with hypertension, (2) residing in the same household as the patient, (3) being able to communicate clearly, and (4) being willing to participate. Family members who were not routinely involved in daily care or who had cognitive impairments that prevented meaningful participation were excluded. Recruitment continued until data saturation was reached, as indicated by repetitive information and the absence of new themes.

2.3 Data Collection

The research team served as the primary instrument and maintained a reflexive stance throughout data collection. Data were obtained through semi-structured, in-depth interviews conducted in Bahasa Indonesia at each participant's home to ensure privacy and comfort. Each participant was interviewed once for approximately 50-60 minutes. The guiding questions were: (1) "How do you personally define your role in supervising the diet of your family member with hypertension?"; (2) "What are your daily experiences and practices related to meal preparation and dietary control within the household?"; and (3) "What are the primary challenges or barriers you encounter while maintaining long-term dietary supervision?" With participants' consent, all interviews were audio-recorded and supported by field notes. Individual interviews were used to obtain detailed personal narratives rather than the broader, less in-depth information commonly generated in group discussions (Guest et al., 2020).

2.4 Data Analysis

The audio recordings were transcribed verbatim and analyzed using Colaizzi's seven-step method. The analysis involved: (1) repeatedly reading all transcripts to become familiar with the data, (2) identifying significant statements related to the phenomenon, (3) formulating meanings from those statements, (4) organizing the formulated meanings into sub-themes and themes, (5) developing an exhaustive description of the phenomenon, (6) identifying its fundamental structure, and (7) returning the findings to participants for validation. The themes were continuously compared with the original transcripts to ensure that the final interpretation remained grounded in participants' accounts.

2.5 Rigour and Trustworthiness

Trustworthiness was strengthened through source triangulation, member checking, and reflexivity. Accounts were compared across participants and against the field notes, while member checking confirmed that the themes represented participants' experiences. Reflexive awareness helped reduce the influence of prior assumptions. Verbatim transcripts, field notes, and a clearly described Colaizzi procedure supported dependability and confirmability, while detailed reporting of the setting, participants, recruitment, and study procedures supported transferability.

2.6 Ethical Considerations

Ethical approval was obtained from the Health Research Ethics Committee of Akademi Keperawatan Kesdam I/BB Binjai (Ethical Clearance No. B/SPer/015/XII/2025). Before each interview, the study purpose and procedures were explained to the participants, and written informed consent was obtained. Participation was voluntary, and confidentiality was maintained by using participant codes P-1 to P-8 in the transcripts and reporting.

3. Results

3.1 Participant Characteristics

Table 1 Demographic characteristics of participants (n = 8)

No.	Participant	Relationship to Patient	Participant Age (years)	Last Education	Participant Occupation
1.	P-1	Wife	52	Junior High School (SMP)	Housewife
2.	P-2	Daughter	34	Bachelor's Degree (Sarjana)	Private Sector Employee
3.	P-3	Husband	58	Elementary School (SD)	Entrepreneur
4.	P-4	Wife	48	High School (SMA)	Housewife
5.	P-5	Son	30	Bachelor's Degree (Sarjana)	Civil Servant (PNS)
6.	P-6	Wife	61	High School (SMA)	Retiree
7.	P-7	Daughter	38	Bachelor's Degree (Sarjana)	Teacher
8.	P-8	Husband	65	Junior High School (SMP)	Retiree

Based on the data in Table 1, the majority of participants were the patient's spouse (husband/wife) (5 people), showing the dominant role of partners in dietary supervision. Participant ages ranged from 30 to 65 years, reflecting that the responsibility for diet supervision was borne by adult family members.

The results of this qualitative study were obtained through in-depth interviews with 8 family members who functioned as diet supervisors for their family members suffering from hypertension. The thematic analysis of the data yielded 3 main themes describing the family's multidimensional role, along with the challenges that accompany it.

Table 2 Themes and sub-themes

Themes	Sub-themes
The Family as an Agent of Practical Control and Food Environment Modifier	Recipe Modification and Salt Reduction Fat and Portion Control Food Gatekeeping
The Family as a Motivator and Provider of Psychosocial Support	Providing Motivation and Positive Reminders Validation of Feelings and Calming Collective Diet Participation
Challenges and Barriers Faced by the Family	Specific Knowledge Limitations Patient Resistance and Old Habits Social Pressure and External Environment

Theme 1: The Family as an Agent of Practical Control and Food Environment Modifier

This theme demonstrates the family's active role in implementing real and preventive actions within the domestic home environment, specifically through kitchen control. This practical function is essential because it directly alters daily food intake.

Sub-theme 1 : Recipe Modification and Salt Reduction

Families consciously reduce or replace salt and high-sodium instant seasonings when cooking. They actively switch to natural spices or herbs as healthy flavor substitutes to maintain food acceptability.

> *"Before, we used a lot of MSG and salt when cooking. Now, salt is maybe just the tip of a teaspoon, and we use a lot of onions and garlic to keep the flavor good."* (Participant 3, Husband)

Sub-theme 2: Fat and Portion Control

Families tightly control the use of oil by minimizing frying practices, preferring cooking techniques like boiling or steaming, and structurally monitoring food portions served to the patient.

"I rarely fry anymore. It's more often boiled or steamed. Even if I do fry, the oil is very little, and I reduce my husband's rice portion by half the usual amount." (Participant 6, Wife)

Sub-theme 3: Food Gatekeeping

Families perform a gatekeeping function by ensuring that restricted food items (such as canned foods, high-sodium snacks, or instant noodles) are kept out of the house to minimize environmental temptations.

"Packaged snacks are no longer on the table. If he wants to eat out, I always remind him not to buy anything with thick sauce or anything too salty." (Participant 2, Daughter).

The results under Theme 1 establish the family as a powerful agent of practical control and food environment modifier. This role is demonstrated through concrete, instrumental actions taken primarily within the kitchen and home environment. Key actions include the conscious modification of recipes by significantly reducing salt and substituting high-sodium ingredients with natural spices (Adjeng Prasodjo, 2024). Furthermore, families manage the patient's intake through portion control and by prioritizing healthy cooking methods such as steaming and boiling over frying. Most critically, the family acts as a vital food gatekeeper, actively removing packaged and restricted items from the house to minimize temptation. These consistent, proactive measures prove that the family is instrumental in establishing and maintaining a dietary supportive environment crucial for the patient's daily adherence to hypertension guidelines (Tarigan, 2021).

Theme 2: The Family as a Motivator and Provider of Psychosocial Support

This theme highlights the essential communication and emotional support dimensions, ensuring that the hypertensive patient feels validated, encouraged, and socially supported rather than isolated by strict therapeutic regimens.

Sub-theme 1: Providing Motivation and Positive Reminders

Caregivers routinely use gentle and affirming reminders regarding dietary compliance, explicitly framing the restrictions around long-term life and health goals rather than administrative mandates.

"I always say, 'Dad, this is for your sake so you can play with your grandchildren for a long time.' So he is motivated, not feeling forced." (Participant 5, Son)

Sub-theme 2: Validation of Feelings and Calming

Families assist patients in processing feelings of anger, restriction, or sadness caused by dietary changes, utilizing constructive communication to de-escalate emotional pushback.

"Sometimes he gets angry because the food is bland. I just stay quiet, listen, and then I say, 'Let's try to find a new recipe later that is low in salt but tastes delicious.'" (Participant 1, Wife)

Sub-theme 3: Collective Diet Participation

To eliminate the social burden of illness, household members adapt their shared eating habits to mirror the patient's dietary requirements.

"We all eat boiled vegetables and bland side dishes now. If we join in, he gets encouraged; he doesn't feel like he's the sickest one." (Participant 7, Daughter)

Theme 2 shows the family's crucial role as a psychosocial support system, extending beyond physical control to address the patient's emotional well-being. The results show that families actively used sensitive emotional strategies, such as validating the patient's feelings of sadness or frustration regarding food restrictions, thereby transforming dietary oversight into an act of genuine care (Harlan et al., 2020). Furthermore, positive reinforcement was used, connecting adherence to long-term personal goals (such as spending time with grandchildren). Most significantly, the practice of collective diet participation, where all household members adopted the same low-salt meals, emerged as a potent form of support. In a social culture where meals were shared, this collective effort effectively eliminated the social burden felt by the patient, thereby strengthening emotional resilience and sustaining long-term adherence (Bazzano et al., 2013).

Theme 3: Challenges and Barriers Faced by the Family

Despite their proactive involvement, family supervisors face an array of informational, behavioral, and environmental limitations that can impede the efficacy of long-term dietary management.

Sub-theme 1: Specific Knowledge Limitations

Caregivers exhibit a generalized understanding of salt avoidance but lack technical literacy concerning hidden sodium, saturated fat thresholds, or how to properly evaluate complex commercial nutrition labels.

"I know I have to reduce salt. But what instant seasoning contains, I don't know exactly. I just forbid all of it." (Participant 4, Wife)

Sub-theme 2: Patient Resistance and Old Habits

Ingrained, decades-old dietary patterns create significant friction, frequently leading to non-compliance or interpersonal conflicts within the household.

> *"He has been eating salty food for decades. If I give him bland food, he will definitely put salt on it secretly. That's the hardest thing to control."* (Participant 8, Husband)

Sub-theme 3: Social Pressure and External Environment

The clinical boundaries maintained inside the home frequently break down during social gatherings, traditional communal events, or when the patient travels beyond direct family observation.

> *"When outside the home, we can only remind him at the beginning. But once he is there, we can't supervise anymore; he will definitely take the delicious foods."* (Participant 5, Son)

Theme 3 shows the significant barriers preventing families from achieving optimal, long-term dietary control for hypertensive patients. The central challenge was the limitation of specific knowledge, where families possessed only superficial awareness (primarily salt restriction) but lacked crucial, in-depth nutritional literacy concerning saturated fats, sugar limits, or the ability to accurately interpret packaged food labels. This educational gap limited comprehensive management. Furthermore, families faced constant behavioral conflict stemming from the patient's old habits and resistance, particularly the decades-long preference for salty and spicy foods, leading to difficult control situations. Finally, the ability to enforce the diet was compromised by social pressure and the external environment, as families lost control over the patient's food choices during social events or when eating outside the home. These barriers collectively emphasize the need for targeted interventions focusing on advanced nutritional literacy and supportive communication skills.

4. Discussion

The results revealed the family's instrumental role, through recipe modification, portion control, and food gatekeeping, as a dynamic, transactional process consistent with Imogene King's Theory of Goal Attainment. The internalization of dietary guidelines (sub-themes 1.1 and 1.2) suggests that families did not operate in isolation; rather, they engaged in a continuous cycle of action, reaction, and interaction with the patient (Alligood, 2010). By adjusting recipes and limiting sodium intake, families effectively translated abstract medical recommendations into practical, shared household practices. This process is critical, as King posits that a transaction occurs only when both parties agree on the means of achieving a health goal. In this context, consistent dietary reminders and meal adjustments represented the interaction phase that enabled successful hypertension management.

The shift from enforced adherence to habituation further indicates that both patient and family reached a stage of mutual goal setting. As dietary behaviors became embedded in daily routines, caregiving evolved into a synchronized lifestyle rather than a burden. Here, the family assumes a regulatory role, functioning as a surrogate decision-maker to ensure that the home environment aligns with agreed health objectives. This aligns with findings by Jian et al. (2026), which identify sustained social support as a key determinant of long-term dietary stability in chronic disease management.

The family's role as a food gatekeeper (sub-theme 1.3) reinforces King's emphasis on the influence of social systems and environment. By removing high-sodium and fatty foods, families actively reshape the patient's immediate environment, limiting exposure to dietary triggers and reducing the likelihood of relapse (Bion & Turner, 2025). This underscores that, for hypertensive patients, the home functions not merely as a living space but as a structured environment where family interventions directly impact health outcomes. Consequently, this study advocates for hypertension interventions that extend beyond individual-focused education to strengthening the family–patient interaction system, thereby promoting sustained dietary adherence (Megasari Winahyu & Imam Muttaqijn, 2021; Septiningsih et al., 2026).

The Family as a Motivator and Provider of Psychosocial Support

The family's role extended beyond physical supervision into the psychological domain. Emotional support, such as providing motivation and validating the patient's feelings of frustration, helped reduce perceived stress. This form of support indirectly enhanced dietary management by encouraging patients to adopt a confrontation-oriented coping style (Megasari Winahyu & Imam Muttaqijn, 2021). By creating a safe emotional environment, families empowered patients to actively engage with their chronic condition rather than resorting to avoidance behaviors. Although lifestyle modification remains essential for hypertension management, many adults struggle to comply due to underlying psychosocial stressors that are often under-recognized. In the absence of adequate psychological support, patients may experience emotional strain related

to dietary restrictions, which undermines adherence. Therefore, integrating psychosocial support into care planning is essential to bridge the gap between clinical recommendations and patients' lived capacity to sustain dietary change (Suriyawong et al., 2023).

The importance of familial psychosocial support in hypertension management is further reinforced by Mariyani et al. (2021), whose findings demonstrated a strong association between emotional support and improved self-care behaviors. Specifically, 55.6% of patients with high emotional support achieved optimal management outcomes, whereas those with moderate support exhibited significantly lower adherence levels. These findings underscore the role of the family as a psychosocial anchor that mitigates internal stress and resistance often associated with restrictive dietary regimens. Through continuous encouragement and emotional stability, families reduce the psychological burden of chronic illness management. This alignment of emotional support transforms clinical directives into a shared domestic responsibility, enabling patients to internalize healthier behaviors and sustain long-term blood pressure control.

A particularly compelling manifestation of this interaction is collective dietary participation, in which family members consume the same low-salt meals. In the Indonesian cultural context, where communal eating is a deeply embedded social norm, such participation becomes a powerful supportive intervention. It reduces the likelihood of stigma and prevents patients from feeling isolated in their dietary restrictions. By removing the sense of individual burden, the family reshapes the perception of the diet from a restrictive punishment into a shared lifestyle practice. Consequently, this study argues that dietary adherence is not solely a function of individual willpower but rather the outcome of a cohesive social system that minimizes psychosocial barriers and facilitates sustained health goal attainment.

Challenges and Barriers Faced by the Family

The study showed that despite the central role families play, their efforts to manage hypertensive patients' diets were limited by several complex factors. These barriers were exacerbated by the diversity in characteristics of the caregivers.

Specific Knowledge Limitations (3.1) was a major issue. While respondents with higher education (bachelor's degrees), such as the patients' children (P-2, P-5, P-7), could more easily absorb nutritional information, the presence of respondents with elementary and secondary education, especially among the spouses (who dominate supervision), showed a significant gap. This group often only understands the generalized instruction to reduce salt but lacks the literacy to read packaged food labels or control saturated fat and sugar, which is crucial for holistic hypertension management. Studies published in the last 5 years consistently stress the need to move beyond basic dietary advice toward improving comprehensive health literacy in chronic disease management (Zhafira Aliefanny & Mona Hastuti, 2025).

The second barrier was patient resistance and old habits. This behavioral conflict was most frequently experienced by the spouses (husband/wife). After decades of sharing salty dishes, the spouse's attempt at diet control was perceived as a restriction, triggering interpersonal conflict. Respondents aged 50 to 60, who make up the majority of spouses, must directly confront the patient's deeply ingrained habits. The literature emphasized that effective communication and a positive family environment were essential to mediate these conflicts and promote long-term behavioral change (Alyafei & Daley, 2025). Furthermore, the family's role as a psychosocial support system must use sensitive emotional strategies, validating the patient's feelings and transforming oversight into genuine care (Harlan et al., 2020).

Social Pressure and the External Environment (sub-theme 3.3) emerged as the most significant challenge, particularly among participants who were employed or actively engaged in social networks. In such contexts, families often lose direct oversight when patients eat outside the home or attend social gatherings. This loss of control is further complicated by the fact that collective dietary adherence within the household is not always fully achieved, often due to limited nutritional literacy among primary food preparers (e.g., housewives or retirees). These constraints are intensified in collectivist cultures where food is central to social interaction, thereby requiring deliberate strategies to sustain dietary adherence beyond the home environment (Lanham et al., 2022). As a result, patients are more likely to deviate from dietary recommendations in external settings, a challenge that cannot be adequately addressed through household supervision alone.

Overall, the variation in age, educational background, and relational roles among respondents underscores the need for more targeted and context-sensitive intervention programs. Enhancing practical nutritional literacy across all educational levels is essential. Spouses, often the primary caregivers, should be equipped not only with knowledge but also with supportive communication skills that foster internal motivation in patients, rather than relying solely on physical monitoring or enforcement (Bhattarai et al., 2024).

Integrating Practical and Psychosocial Roles

This study demonstrated that the practical and psychosocial roles of the family are inextricably linked and mutually reinforcing. The structural changes made to the food environment (practical control) provided the necessary physical framework for diet adherence, but it was the emotional validation and collective participation (psychosocial support) that ensured the sustainability of these changes(Mak et al., 2026). Without emotional alignment, strict dietary control could be perceived by the patient as a source of conflict or a loss of autonomy. However, when integrated, the family's dual role created a holistic supportive social system that transformed clinical dietary requirements into a shared family identity(Reichenberger et al., 2020). This synergy effectively achieved the goal attainment described by King, where the interaction between the family and the patient resulted in a unified movement toward optimal health.

5. Conclusion

In conclusion, this qualitative study shows that the family's role in hypertension diet management is a multidimensional synergy of instrumental control and psychosocial support. Beyond supervision, families function as food gatekeepers through active recipe modification and environment control, which serve as primary determinants of daily adherence. Crucially, this study observes that collective diet participation, where family members consume the same low-salt meals, is the most effective strategy to eliminate the patient's social burden and prevent isolation.

The results suggest that suboptimal hypertension control often results from the underutilization of the family's potential as a supportive social system. Therefore, this study recommends that Puskesmas interventions shift from individual-centered education to holistic family health literacy. Interventions must prioritize supportive communication skills and collective dietary habits to foster internal motivation and achieve sustainable behavioral change in hypertensive patients.

References

Adjeng Prasodjo, R. (2024). Literature Review: Strategies to Reduce Sodium Intake through Salt Reduction to Prevent Hypertension. *Media Gizi Kesmas*, *13*(1), 521–529. https://doi.org/10.20473/MGK.V13I1.2024.521-529

Alyafei, A., & Daley, S. F. (2025). The Role of Dietary Lifestyle Modification in Chronic Disease Prevention and Management. *StatPearls*. https://www.ncbi.nlm.nih.gov/books/NBK587401/

American Heart Association. (2020). *Top 10 Things to Know About the New AHA/ACC High Blood Pressure Guideline | American Heart Association*. https://www.heart.org/en/health-topics/high-blood-pressure/the-facts-about-high-blood-pressure/high-bp-top-10

Bazzano, L. A., Green, T., Harrison, T. N., & Reynolds, K. (2013). Dietary Approaches to Prevent Hypertension. *Current Hypertension Reports*, *15*(6), 694. https://doi.org/10.1007/S11906-013-0390-Z

Bhattarai, A., Shakya, R., & Bista, D. (2024). Impact of Pharmacist-Led Intervention on Adherence to Inhalers, Inhalation Technique, and Disease Control Among Asthma/COPD Patients in a Resource Limited Center: An Interventional Study. *Patient Preference and Adherence* , *18*, 1395–1408. https://doi.org/10.2147/PPA.S460810

Chham, S., Buffel, V., Ir, P., Ku, G. M., Chhim, S., van Damme, W., Van Olmen, J., & Wouters, E. (2026). Understanding the role of family social support in the medication adherence to hypertension treatment in Cambodia. *BMC Public Health*, *26*(1), 985. https://doi.org/10.1186/s12889-026-26628-6

Creswell, J. W., & Creswell, J. D. (2018). Research Design: Qualitative, Quantitative, and Mixed Methods Approaches - John W. Creswell, J. David Creswell - Google Books. In *SAGE Publications, Inc.*

Cuevas, L. E., Santos, V. S., Lima, S. V. M. A., Kontogianni, K., Bimba, J. S., Iem, V., Dominguez, J., Adams, E., Atienzar, A. C., Edwards, T., Squire, S. B., Hall, P. J., & Creswell, J. (2021). Systematic review of pooling sputum as an efficient method for xpert MTB/RIF tuberculosis testing during COVID-19 pandemic. *Emerging Infectious Diseases*, *27*(3), 719–727. https://doi.org/10.3201/eid2703.204090

Guest, G., Namey, E., O'Regan, A., Godwin, C., & Taylor, J. (2020). *Comparing Interview and Focus Group Data Collected in Person and Online*. https://doi.org/10.25302/05.2020.ME.1403117064

Harlan, E. A., Miller, J., Costa, D. K., Fagerlin, A., Iwashyna, T. J., Chen, E. P., Lipman, K., & Valley, T. S. (2020). Emotional Experiences and Coping Strategies of Family Members of Critically Ill Patients. *Chest*, *158*(4), 1464. https://doi.org/10.1016/J.CHEST.2020.05.535

Kementerian Kesehatan RI. (2018). *Hipertensi secara global - Penyakit Tidak Menular Indonesia*. https://p2ptm.kemkes.go.id/infographic-p2ptm/hipertensi-penyakit-jantung-dan-pembuluh-darah/page/43/hipertensi-secara-global

Khoirunnisa, R., Ridwan, S., Dhiemitra, A., & Dewi, A. (2024). *Family Support and Dietary Adherence in Individuals with Type 2 Diabetes Mellitus in Banten , Indonesia*. *19*(28), 27–34.

Lanham, A., Lubari, E., Gallegos, D., & Radcliffe, B. (2022). Health promotion in emerging collectivist communities: A study of dietary acculturation in the South Sudanese community in Logan City, Australia. *Health Promotion Journal of Australia*, *33*(1), 224–231. https://doi.org/10.1002/hpja.491

Mak, P. Y., Tyrovolas, S., & Liu, J. Y. W. (2026). Family Support in Healthy Dietary Behaviours Among Community-Dwelling Older Adults: A Scoping Review. In *Nutrients* (Vol. 18, Number 6). Multidisciplinary Digital Publishing Institute (MDPI). https://doi.org/10.3390/nu18060963

Mestre, T. D. (2024). *Family Self-Care in Chronic Disease Management : An Evolving Care Pattern ?* https://doi.org/10.1177/23779608231226069

Ministry of Health, R. I. (2018). *Hypertension globally: Non-Communicable Diseases in Indonesia*. https://p2ptm.kemkes.go.id/infographic-p2ptm/hipertensi-penyakit-jantung-dan-pembuluh-darah/page/43/hipertensi-secara-global

Ministry of Health, R. I. (2024). *The Danger of Hypertension Lurks for Young Indonesians*. https://www.badankebijakan.kemkes.go.id/bahaya-hipertensi-mengintai-anak-muda-indonesia/

National Heart, Lung and Blood Institute (NHLB, N. (2025). *DASH Eating Plan*. https://www.nhlbi.nih.gov/education/dash-eating-plan

Reichenberger, J., Schnepper, R., Arend, A. K., & Blechert, J. (2020). Emotional eating in healthy individuals and patients with an eating disorder: Evidence from psychometric, experimental and naturalistic studies. *Proceedings of the Nutrition Society*, *79*(3), 290–299. https://doi.org/10.1017/S0029665120007004

Tarigan, A. R. (2021). Analysis Of Family Support And Diet Compliance In Hypertension Patients. *Contagion: Scientific Periodical Journal of Public Health and Coastal Health*, *3*(1), 16. https://doi.org/10.30829/CONTAGION.V3I1.9123

World Health Organization. (2021). Guideline for the pharmacological treatment of hypertension in adults. Web Annex A. Summary of evidence. *WHO*.

World Health Organization. (2023). *Hypertension Facts and Figures*.

Yang, Y., Yu, D., Piao, W., Huang, K., & Zhao, L. (2022). Nutrient-Derived Beneficial for Blood Pressure Dietary Pattern Associated with Hypertension Prevention and Control: Based on China Nutrition and Health Surveillance 2015–2017. *Nutrients*, *14*(15). https://doi.org/10.3390/nu14153108

Zhafira Aliefanny, & Mona Hastuti. (2025). Application of Progressive Muscle Relaxation in Hypertensive Patients with Acute Pain Nursing Problems in Mrs. N In the Medan Sunggal Community Health Center UPT Working Area. *Praba Journal: General Health Journal*, *3*(3), 157–162. https://doi.org/10.62027/praba.v3i3.538