



NASW SPECIALTY PRACTICE SECTIONS  
SPRING/SUMMER ■ 2022

# Health

SECTION  
CONNECTION

## Letter from the Chair



Back in February, I read “Women Should Take These 3 Things to Heart,” a short, focus piece for National Heart Month.

Do you know what these “three things” are?

- 1) **Know** that heart attack symptoms in men and women can differ. (Yes, you read it here—maybe for the first time!)
- 2) **Know** the risk for heart attack and for stroke. (Ditto!)
- 3) **Know** how to reduce that risk. (Something your doctor said during your last annual physical might ring a bell.) (Malloy, 2022)

Know, too, that we, who put our hearts in our work, can obtain our personal guide to a healthy heart courtesy of the Mayo Clinic!

But wait! In the Health Specialty Practice Section, we may need to go no further than this issue to get information on cardiovascular health for our clients (and even ourselves). Dr. Valire Copeland and Dr. Suzanne Cross, members of the Health Section Committee, share their expertise and work with special populations experiencing cardiovascular disease.

First, Dr. Copeland carries us into the world of “Cardiovascular Disease and African American Women.” For example, did you know cardiovascular disease (CVD) is the leading cause of death for women in the United States? Or, that women’s hearts are smaller than men’s hearts (intuitively, yes), or that heart health disparities are linked to social determinants of health? We social workers may know some or all these facts, but Dr. Copeland takes us further, helping us to recognize specific conditions, circumstances, and lifestyles that can affect those we serve. She provides essential information for our professional and personal use.

Next, in “Impact of Cardiovascular Disease on American Indian/Alaska Native Populations,” Dr. Cross helps us better understand CVD among this particular group. To shed light on how culture, tribal practices, and time-honored systems of spiritual and physical health influence American Indian and Alaska Native (AI/AN) women, she tells us how we can best deliver services to them while respecting and considering AI/AN health care histories and the impact of social work’s unique (not always positively perceived) history with these populations. Dr. Cross offers targeted recommendations for social work professionals to adopt prior to and during work with AI/AN clients.

March was Social Work Month; we hoped it found you well, challenged, engaged, and learning!

**Julia Winchester Buckey, Chair**

### REFERENCE

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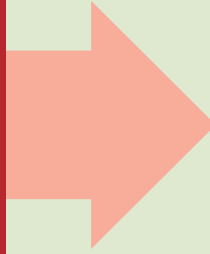


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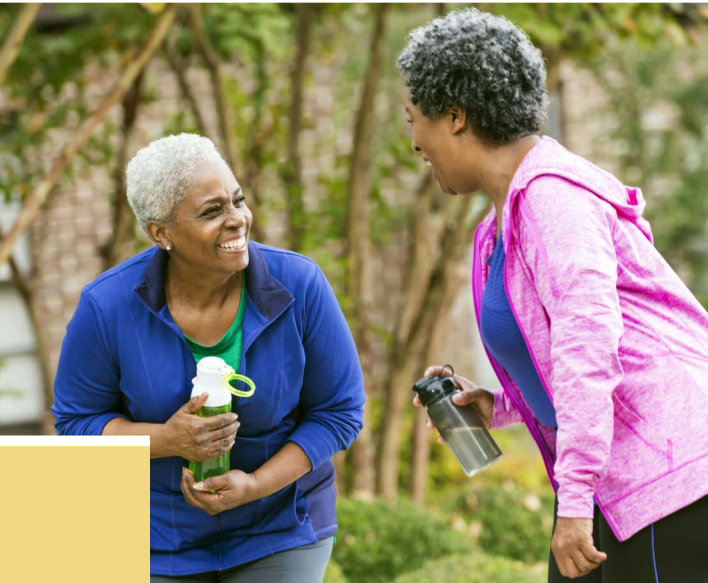
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# CARDIOVASCULAR DISEASE and African American Women

**VALIRE CARR COPELAND, PHD, MPH, MSW**



Cardiovascular disease (CVD), the leading cause of death for women in the United States, claims more than 400,000 lives each year (Center for Disease Control [CDC], 2019). Without receiving treatment to restore blood flow, patients can suffer heart damage that can lead to a heart attack. According to the American Heart Association (AHA, 2019), healthier lifestyle choices can prevent 75 percent of CVD cases in women.

Although women in other racial and ethnic groups report higher poverty and lower education, African American women (AAW) have the poorest health outcomes overall, exceeding those of women in any other group. Social workers can help AAW by learning about heart health and key disparities—and how these factors affect AAW, how social workers can be proactive in aiding clients to safeguard heart health, and how they can work to obtain needed care for this client population.

## **HEALTH DETERMINANTS AND HEALTH DISPARITIES**

Differences in health outcomes exist based on distributional variation in illness and disease. A variety of health determinants contribute to these differences. “[H]ealth determinants are the range of personal, social, economic, and environmental factors that determine the health status of individuals or populations. They are embedded in our social and physical environments” (Sable et al., 2012, p. 69). The role sociocultural factors play in

health status and outcomes that trend negatively is termed *health disparities*. To understand what a health disparity is requires deciding if the term means something other than simply a difference that has been considered value neutral. If health disparities are understood as something more than mere variations, then two additional questions must be resolved: disparities of what and for whom (Wexler & Copeland, 2017).

Health disparities, linked to social determinants, include “family, community, income, education, sex, race/ethnicity, geographic location, and access to health care, among others, present in our physical, natural, and built environments” (Sable et al., 2012). Because distribution can negatively impact access to and quality of health care and its outcomes, some groups—given where they live, work, play, and learn—have more than their share of negative health outcomes.

Health disparities also point to differences in health status outcomes among racial and ethnic minority population groups, and they stem from such factors as race, ethnicity, socioeconomic status, age, zip code, gender, disability status, and sexual orientation (Orgera & Artiga, 2018). Other AHA-recognized areas of impact include individual genetics or history of heart disease, unhealthy lifestyles (ranging from eating habits to lifestyle choices over the life span), accumulated structural racism, stress, depression, aging, and gender (AHA, 2019; Copeland et al., 2017).

The literature on CVD and women consistently indicates disparities for AAW (Pool et al., 2017). These gaps appear to have existed for years and show little evidence of narrowing among women of color. Clearly, knowledge of CVD symptoms and personal risk factors as well as committing to decreasing controllable risk factors early in life are key primary prevention strategies (Fryer et al., 2012; Zhong et al., 2020).

### **HEART DISEASE IN WOMEN, AAW, AND OVERALL, HEART RISK**

Multiple risk factors in women appear to be more severe for leading to CVD when compared

with risk factors in men. Some factors are genetically predisposed and out of individual control: family history, heredity, and genetics (histories of high blood pressure, high blood cholesterol, diabetes, etc.). At least one of these predispositions exists in 47 percent of all Americans (Fryer et al., 2012). For example, women have a 25 percent increased risk for coronary artery disease from smoking and a greater likelihood to develop diabetes-related CVD than do men. As heart attack risk increases with hypertension, it, when coupled with diabetes, leads women to experience greater severity with this condition than men with the same comorbidity. Further, when coupled with several individual reproductive milestones (early menarche, early menopause, and miscarriage), some women’s histories further increase the risk for CVD (AHA, 2019).

Other risk factors affect AAW and African American men differently. AAW are more likely than their male counterparts to become obese, develop high cholesterol (a known contributor to heart disease), and exercise less (Zhong et al., 2020). Researchers continue their search for answers to the disparity of both African American men and women having better cholesterol levels than do White men and women (AHA, 2019). By assessing ways risk factors function among women—while improving our understanding of key risk factors and prevention strategies—we can work toward better overall health for AAW.

Black and Hispanic women seem less likely than their White counterparts to be aware of heart attack symptoms (Copeland et al., 2017).

Only 36 percent of Black and 34 percent of Hispanic women, compared with 65 percent of White women, knew heart disease was the leading cause of death in their subgroup population (CDC, 2019). This lack of knowledge contributes to health disparities—such as it functions as a barrier to women of color in accessing health care services.

Not only is heart disease a leading cause of death in AAW, but it is the number-one cause of disability in women overall (CDC, 2019). Despite increases in public health awareness and education campaigns, promotion projects, and a national focus on women’s health, only 54 percent of women the United States know that heart disease is their leading cause of death. Those who are unaware of this risk may be less educated, lack health insurance, and have no source of primary health care.

### **SIGNS AND SYMPTOMS**

According to the CDC, most women who die suddenly from heart disease had no previous symptoms. Although the absence of symptoms does not alleviate the risk for heart disease, it does reinforce heart disease as the “silent killer.” That said, more knowledge about risk factors and lifestyle choices can reduce women’s risk for CVD (CDC, 2019). The warning signs and symptoms of heart disease vary depending on the disease severity. For example, many individuals experience chest discomfort—or even a heart attack itself—as the first warning sign (CDC, 2019). This discomfort may last more than a few minutes. Other symptoms can include pain or discomfort in the jaw, neck, back, or stomach; overall weakness, light-headedness, nausea, or cold sweats; pain or discomfort in the

arms or shoulders; and shortness of breath. Five or more of these symptoms should trigger a 911 call. Immediate treatment can save a life, reduce heart muscle damage, and result in best treatments (CDC, 2019).

### **REDUCING RISKS**

Risks for developing heart disease can be lowered by adopting a healthy lifestyle and eating habits. We know diets filled with fruits, vegetables, and fiber—when coupled with lower sodium, sugar, saturated and trans fats, and cholesterol intake—help reduce the chance of developing CVD. So, too, does weekly physical activity, not using tobacco products, and limiting alcohol consumption (Fryer et al., 2012; Zhong et al., 2020). Self-care strategies likewise lower risk, as they are linked to changes in lifestyle.

Considerations to these rules suggest that although physical inactivity increases heart risk, physical activity decreases it (Fryer et al., 2012; Zhong et al., 2020). AAW with lower levels of physical activity have higher levels of health risk than do their non-Hispanic White counterparts (CDC, 2019; Chomistek et al., 2015). Social determinants of health can support positive, beneficial living environments.

### **IMPLICATIONS FOR SOCIAL WORKERS**

CVD kills both men and women in the United States; however, women, and especially AAW, are at higher risk than any other racial and ethnic group for this chronic disease. A bio-psycho-social approach is important to understand when treating individuals from an integrated health perspective. Social workers must understand the health conditions that place AAW at greater risk for CVD. From a sociocultural approach,

a genuine attempt to recognize the impact of lifestyle behaviors, cultural factors, genetics, and social determinants that affect AAW's health status is suggested. For social work client's when necessary, advocacy, information, and referral may be required to obtain or facilitate appropriate health care services.

Only a holistic approach can help identify the risk factors for CVD. Among risk factors are those that can be controlled and those that can be managed. Social workers who work with specific racial and ethnic groups of women can, in part, facilitate medical adherence for improved health status outcomes, by using tailored health behavior education and health promotion efforts. These practitioners should strive for authenticity; they should attempt to forge a trusting relationship with these clients, which could help mitigate health disparity gaps for women of color. Finally, social workers' knowledge base in health care behavior and promotion must extend to social and environmental determinants,

which can affect individual risk factors and help women become role models for their families. As social workers, we need to recognize the seriousness of the disease—its signs and symptoms—and then what we must do to intervene.

**Valire Carr Copeland, PhD, MPH, MSW, Professor, School of Social Work & Graduate School of Public Health, University of Pittsburgh, can be reached at: [sswvcc@pitt.edu](mailto:sswvcc@pitt.edu).**

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## UPCOMING LIVE SPS WEBINARS

**FRIDAY, APRIL 22, 2022 (11:30 AM – 12:30 PM ET)**

**Grace Under Fire - Partnering with Parents who are Behaving in a Hostile or Obstructive Way in a School Setting**

**Presenter:** D. Natasha Scott, Ed.D., MSW

**CE Category:** 1 Social Work contact hour

**Cost: SPS Members:** Free

In this webinar, Dr. Scott will review best practices for school social workers working with challenging parents and explore parents' perspectives on working with school social workers. The session will also review the NASW Code of Ethics for guidance about work with challenging parents.

**To register visit:** The SPS Webinar Catalog

**WEDNESDAY, APRIL 27, 2022 (1 – 2:30 PM ET)**

**“When you lift from the bottom, everybody rises!” Social Work and the Poor People’s Campaign: A National Call for Moral Revival**

**Presenter:** Mary Bricker-Jenkins, PhD, MSW, LCSW (ret), Maureen D. Taylor, and MSW, Kristin Colangelo LCSW, LCADC, CCS

**CE Category:** 1.5 Social Work contact hours

**Cost: SPS Members:** Free

The contemporary Poor People’s Campaign: A National Call for Moral Revival aims to eradicate the interlocking systemic injustices of poverty, racism, militarism, and environmental devastation; it also confronts the false moral narrative that sustains them. Social workers involved in the Poor People’s Campaign have found that it enhances the effectiveness and ethical dimensions of their daily work from the clinic to the community and from direct practice to policy and research. In this webinar we explore how and why that happens, and the ways that the campaign turns pain into power for lasting change.

**To register visit:** The SPS Webinar Catalog



# IMPACT OF CARDIOVASCULAR DISEASE on American Indian/Alaska Native Populations

SUZANNE CROSS, PHD, ACSW, LMSW, LLC



As of February 19, 2020, the Bureau of Indian Affairs (BIA) of the United States

legally recognized 574 American Indian and Alaska Native (AI/AN) tribes (National Congress of American Indians, 2020). An additional 63 tribes not recognized by the BIA are recognized by the states in which they reside (National Congress of State Legislators). (Salazar, 2020). Regardless of recognition status, all tribal nations have a strong commitment to intergenerational families; a desire to retain and revitalize languages, traditional cultural beliefs, and holistic health and healing practices; and a respect for the water and the land. Yet, tribal nations are diverse in terms of region, environment, religions, languages, traditions, assets, and health concerns.

Despite such diversity across tribal nations, cardiovascular disease (CVD) is the leading cause of death for AI/AN men and women (Boyd et al., 2020). Roughly 36 percent of AI/AN patients with CVD die before age 65, compared with 14.7 percent of non-Hispanic White and 31.5 percent of Black patients (Beck, 2020). Although AI/AN people account for less than 2 percent of the U.S. population, they make up 18

percent of U.S. deaths caused by heart disease (American Heart Association, 2019). The U.S. AI/AN population, approximately 5.2 million people, are more likely than White Americans to die from treatable conditions (Breathett et al., 2020) and have a life span 4.4 years less than that of the general U.S. population (Lindsay, 2018).

Contributing factors for CVD among the AI/AN population include diabetes, exposure to environmental chemicals (toxic metals, arsenic from groundwater, etc.), hypertension, decreased renal function, and obesity—all significant predictors of coronary heart disease (Breathett et al., 2020). Major health-related issues include, but are not limited to, access to health care—20 percent of AI/AN patients do not have health insurance—poverty, substance abuse, and lack of transportation (Boyd et al., 2020). In addition, constant strains of cultural dislocation, coupled with historical, intergenerational, and current traumas, may create discord in families both on and off reservation lands. Further, significant losses, discrimination, and microaggressions affect access to AI/AN health care and its delivery (Cross & Day, 2015). All these negative

experiences are stressors that contribute to CVD; many of them may lead AI/AN patients to mistrust the Western, mainstream health care system and avoid seeking treatment there.

In the United States, a woman dies nearly every 80 seconds from heart disease; women who have heart attacks are more likely to die within a year (Mehta et al., 2016). As a result of the Strong Heart and Strong Heart Family studies, which included both men and women, Dr. Clemma Muller, the lead author of the study stated, “It’s unclear why men were seeing an improvement in mortality rates and not women.”

One possibility is that women who do get CVD are getting sicker (American Heart Association, 2019). Women are more likely than men to delay seeking treatment because they interpret symptoms as temporary and not urgent, wish to consult with a family member first, or fear embarrassment if the symptoms aren’t serious; women also may not complete rehabilitation services due to family and work obligations (Mehta et al., 2016). Women’s bodies differ significantly from men’s. For example, the average female heart is two thirds the size of the average male heart, yet CVD-related medical studies

and trials continue to predominately use male subjects.

Improving outcomes for women with heart disease depends on addressing gender-specific characteristics and disparities. Health providers must find ways to improve overall awareness of CVD, recognition of symptoms, treatment options, and adherence to prevention programming (Mehta et al., 2016). Unfortunately, 45 percent of women are unaware that CVD is a threat to them (Mehta et al., 2016.)

Obesity and diabetes can contribute to CVD and in the AI/AN population AI/AN women have higher rates of obesity compared with non-AI/AN women (Breathett et al., 2020). Programs to reduce diabetes risk through physical activity and weight loss, control over low-density lipoprotein cholesterol, hypertension, tobacco cessation, and toxic-metal mitigation can help lower CVD rates in this population (Mehta et al., 2016).

It is also critical for health care professionals to recognize the importance of traditional AI/AN healing and treatment modalities (Cross & Day, 2015). Spiritual beliefs promote well-being and are maintained through practice and ceremonies. Tribal cultural

spirituality is associated with better mental and physical health; thus, some AI/AN women may attempt to heal themselves with their own methods, such as prayer, smudging, meditation, and participation in ceremonies. Others may seek healing using either Western biomedical or culturally traditional Native healing—concurrently, alternately, or serially (Cross & Day, 2015). Professional respect for traditional AI/AN healing can open communication with a patient; to ignore or disparage these traditions is to leave some patients feeling part of their core belief system is invalid. Incidents of discrimination and microaggressions in health care settings correlate with worse physical and mental health among AI/AN patients with chronic diseases. Additionally, a fourth of AI/AN patients reported some discriminatory encounter, and 15 percent claimed to have avoided seeking health care for themselves or their family due to anticipated discrimination (Cowling, 2018). Targeted community-based outreach in tribal settings can encourage increased use of health services. In ways that recognize bias and respect culture, social workers must build relationships, seek the support of tribal leaders, and understand barriers and needed resources (Cowling, 2018).

### WHAT SOCIAL WORKERS SHOULD KNOW

Today's social workers must first understand the history of the social work profession with the AI/AN population. Unfortunately, the profession too frequently took part in an overall plan of cultural erasure. Social workers were often tasked with carrying out acts of

relocation and termination, including placement of children in boarding schools, child removal, adoption outside of tribal nations, and female sterilization (Cowling, 2018). Understanding this history is vital for social workers who work with the AI/AN population today.

### RECOMMENDATIONS FOR ALL SOCIAL WORKERS

- Dispel stereotypes: Address discrimination and microaggression to increase quality and continuation of care (Beck, 2020; Cross & Day, 2015).
- Employ a strengths-based approach to improve health: Be mindful of tribal identity and traditional, holistic approaches to improving physical and mental health in AI/AN communities (Boyd et al., 2020).
- Develop a knowledge of how historical, intergenerational, and present-day traumatic stressors impact and form AI/AN expressions of pain: Become aware of how AI/AN women describe pain levels using the same terminology for both moderate and severe pain (Cross & Day, 2015).
- Conduct literature reviews to explore methods to better prevent CVD among AI/AN women and enhance support for those living with the disease.
- Enlist women holding traditional leadership roles to assist in guiding and implementing effective heart health programs—for example, survivor panels in which AI/AN women living with heart disease can share

personal stories, which can be a rich resource for prevention and treatment programs.

- To empower the AI/AN communities, recommend the use of talking circles, which have been instrumental in providing education on diabetes and substance use reduction.
- Ask pharmacists on reservations, often consulted by tribal members, to share valuable information about CVD.
- Recruit community health workers to improve health outcomes in this underserved population.
- Create culturally sensitive, specially tailored Web sites (Boyd et al., 2020; Cross & Day, 2015).
- Share factual health information during pow wows, AI/AN conferences, tribal health department meetings, tribal elder programs, and other relevant events.

### CONCLUSION

Both AI/AN men and women have shortened life spans—in part from CVD. The social work profession can assist the AI/AN population by supporting health care that is based on AI/AN cultural beliefs and values. It is critical that social workers understand the history and resultant rationale as to why AI/AN patients are reluctant to engage in the mainstream, Western health care system. Culturally relevant programming as well as practitioners' increased attention to health disparities and willingness to understand and actively work to

reduce CVD-related deaths in the AI/AN population would do much to enhance health care outcomes in the United States.

**Suzanne Cross, PhD, ACSW, LMSW, LLC, has a certificate in gerontology from the University of Michigan. She is associate professor emeritus at Michigan State University, School of Social Work. Dr. Cross is a private consultant and a citizen of the Saginaw Chippewa Indian tribe of Michigan. She can be reached at [dr.cross.consultant@gmail.com](mailto:dr.cross.consultant@gmail.com).**

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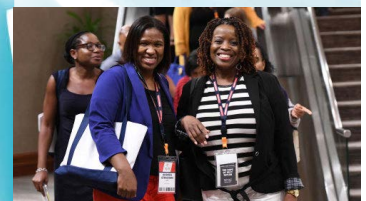
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# Call for

## Social Work Practitioner Submissions

NASW invites current social work practitioners to submit brief articles for our specialty practice publications. Topics must be relevant to one or more of the following specialized areas:

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- Aging
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- Child Welfare
- Children, Adolescents, & Young Adults
- Health
- Mental Health
- Private Practice
- School Social Work
- Social & Economic Justice & Peace
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For submission details and author guidelines, go to [SocialWorkers.org/Sections](https://www.socialworkers.org/Sections). If you need more information, email [sections@naswdc.org](mailto:sections@naswdc.org).



### *Did You Know?*

Smoking weakens the immune system and increases the risk of respiratory infections. Many of the underlying health conditions that place individuals at greater risk for severe complications from COVID-19 are often caused by tobacco use. There is also growing evidence that e-cigarette use can harm lung health.

For more information, visit  
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