Social-Strata-Related Cardiovascular Health Disparity and Comorbidity in an Aging Society: Implications for Professional Care

Amy L. Ai and Lynn T. Carrigan

Cardiovascular disease (CVD) is on the rise in the aging population of the United States. Heart disease is the leading cause of death, hospital bed use, and social security disability. Enhancing knowledge about CVD may improve social work’s professional role in the health care system. This article focuses on a pressing CVD-related issue that needs professional attention—CVD health disparity and the associated mental health comorbidity (depression and anxiety) that predicts poor CVD outcome. Findings from a large-sample clinical trial by the National Institutes of Health call for innovative psychosocial intervention. Implications for professional practice, research, and education are outlined.

KEY WORDS: anxiety; cardiovascular disease; depression; gender; health disparity; mental health comorbidity

Aging-related cardiovascular disease (CVD) includes coronary heart disease (CHD), ischemic attack in the brain (stroke), high blood pressure (hypertension), irregular heart beat (arrhythmia), and congestive heart failure (CHF). The demographic trend of population aging in the United States will inevitably increase the incidence of CVD, a fact that presents both challenges and opportunities for the social work profession, especially as related to new findings about significant health disparity and mental health comorbidity in CVD. As a major force in the health system, the social work profession must consider a dramatically expanded role in CVD-related health, mental health, and aging care in its commitment to services for disadvantaged populations.

Newly published national data spotlight the increasing need for CVD-related social services for the aging population. Among older people with CHD, about half have difficulty with one or more activities of daily living (ADL), and two-fifths require assistance (American Heart Association [AHA], 2005). They are more likely to use prescription drugs and social services (for example, a social worker, adult day care, rehabilitation, transportation, and Meals on Wheels) than their younger counterparts. They also tend to experience early retirement and low satisfaction with retirement (National Academy on an Aging Society, 2000a). Advanced age and social and environmental factors (for example, insufficient home care, living alone, and coping difficulties) increase the risk of hospital readmission (Berkman, Millar, Holmes, & Bonander, 1991). A study showed that nearly half of CHF readmissions were primarily due to social problems and lack of community services (Proctor, Morrow-Howell, Li, & Dore, 2000).

According to national data and current research, social-strata-related disparity and associated comorbidity further complicate the increasing demand for professional care. However, many social workers in health care and education may not recognize the scope of the issue needing their clinical attention. In this article, we aim to increase awareness of and enhance professional influence in cardiac care for an aging society.

CVD-RELATED HEALTH DISPARITIES

In the past century, CVD has had a significant effect on society and the U.S. population. Social workers must be attentive to the financial, socioeconomic, and public health consequences of CVD and the related disparity in health. According to the AHA (2005), the estimated cost of CVD and stroke was $393.5 billion in 2005, nearly $175 billion more than that of all cancers and HIV infections. Indeed, CVD claims as many lives as the next five leading causes of death combined (that is, cancer, chronic lower
Since 1984, more women have died of CVD than men, and this gap continues to increase dramatically.

respiratory diseases, accidents, diabetes mellitus, and influenza or pneumonia) each year.

With narrowing coronary arteries that lead to insufficient blood and oxygen supply, CHD causes angina pectoris (chest pain), myocardial infarction (MI, or heart attack), and sudden cardiac arrest. CHD is the single largest killer of Americans among all CVDs (National Academy on an Aging Society, 2000a) and the leading reason for short-stay hospitalization and permanent disability in the U.S. labor force. It accounts for nearly one-fifth of social security disability insurance payments (AHA, 2003, 2005; National Academy on an Aging Society, 2000a).

Differential Effects of CVD, by Gender and Socioeconomic Status

Gender Effects. CVD is the leading cause of premature death for men and women of all racial and ethnic groups, claiming 1.4 million lives in 2002 (AHA, 2005). Since 1984, more women have died of CVD than men, and this gap continues to increase dramatically (AHA, 2003). Average annual rates of first major CVD event rise from 0.7 percent for men ages 35 to 44 to 6.8 percent at ages 85 to 94 (AHA, 2005). Comparable rates occur 10 years later for women, but the gender gap narrows with advancing age. The rate of CVD is greater in women than men after age 75.

After menopause, women are two to three times more likely to have CHD than premenopausal women of the same age (AHA, 2005). The average age of a person experiencing a first MI is 65.8 for men and 70.4 for women. Because of their older age, more women (nearly two-fifths) than men (one-quarter) will die within a year after suffering a recognized MI and will die within a few weeks of any occurrence. Among survivors, MI considerably increases the risk of another MI, sudden death, angina pectoris, heart failure, or stroke. Within six years, slightly fewer than one-sixth of men and about half of women will be disabled with heart failure.

Socioeconomic Status (SES)-Related CHD Disparity. CVD strikes many workers of lower SES. Its mortality and morbidity are also related to SES, suggesting the indirect influence of unhealthy food, lack of access to health care, and increased socioenvironmental stress (Krantz, Sheps, Carney, & Natelson, 2000). The premature death rate from CHD for male manual workers (for example, builders) is almost two-thirds higher than that for nonmanual workers (for example, lawyers). The comparable rate for female manual workers is more than twice as high as for their nonmanual counterparts (AHA, 2003). Monthly earnings for workers with heart disease are considerably lower than for other workers (National Academy on an Aging Society, 2000a).

Differential Effects of CVD, by Race and Ethnicity

The burden of CVD falls disproportionately on several racial and ethnic minority populations (AHA, 2003, 2005). National data on major types of CVD are summarized by race and ethnicity and sometimes by gender in the following sections (the most recent numbers are shown in Table 1) (AHA, 2005). Although not all minority groups show the worst health conditions in every CVD category, the related health gaps between them, especially between black and white people, are nonetheless apparent.

Racial Disparities in Major Disabling Types of CVD. Rates of CVD prevalence are higher in black than in white people of both genders (AHA, 2005) (Table 1). Data from a different source, the Centers for Disease Control and Prevention (1998), show that black people are more likely than white people to die from heart disease, and this racial gap has widened since the 1980s. As for MI, the most deadly form of CHD, although rates are higher in white men than in black men, they are lower in nonblack women than in black women (Table 1) (AHA, 2005). In addition, stroke is a leading cause of serious, long-term disability in the United States. In those ages 65 to 85, racial and ethnic minority populations have a higher relative risk of stroke death (AHA, 2003). More recent information shows that both American Indians or Alaska Natives and black people have higher rates of stroke, in comparison with white people of both genders (Table 1) (AHA, 2005). Furthermore, rates of CHF, also a highly disabling condition, are higher in black men and women and Mexican American men than in white men and women.

Hypertension, Health Insurance, and Race. Nearly one in three Americans has hypertension. Of those with the condition, one-third are unaware of it
Table 1: CVDs, by Race and Gender

<table>
<thead>
<tr>
<th>Race and Gender</th>
<th>CVD Prevalence (%)</th>
<th>CVD Mortality</th>
<th>CHD Prevalence (%)</th>
<th>MI Prevalence (%)</th>
<th>Stroke Prevalence (%)</th>
<th>CHF Prevalence (%)</th>
<th>Hypertension Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Male</td>
<td>34.3</td>
<td>8.9</td>
<td>5.1</td>
<td>2.3</td>
<td>2.5</td>
<td>2.5</td>
<td>30.6</td>
</tr>
<tr>
<td>White Female</td>
<td>32.4</td>
<td>5.4</td>
<td>2.4</td>
<td>2.6</td>
<td>1.9</td>
<td>1.9</td>
<td>31.0</td>
</tr>
<tr>
<td>Black Male</td>
<td>41.1</td>
<td>7.4</td>
<td>4.5</td>
<td>4.0</td>
<td>3.1</td>
<td>3.1</td>
<td>41.8</td>
</tr>
<tr>
<td>Black Female</td>
<td>44.7</td>
<td>7.5</td>
<td>2.7</td>
<td>3.9</td>
<td>3.5</td>
<td>3.5</td>
<td>45.4</td>
</tr>
<tr>
<td>Mexican American Male</td>
<td>29.2</td>
<td>5.6</td>
<td>3.4</td>
<td>2.6</td>
<td>2.7</td>
<td>2.7</td>
<td>27.8</td>
</tr>
<tr>
<td>Mexican American Female</td>
<td>29.3</td>
<td>4.3</td>
<td>1.6</td>
<td>1.8</td>
<td>1.6</td>
<td>1.6</td>
<td>28.7</td>
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<td>4.8</td>
<td>2.4</td>
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<td>—</td>
<td>18.2</td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td>5.0</td>
<td>2.4</td>
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<td>—</td>
<td>—</td>
<td>16.7</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td></td>
<td>3.6</td>
<td>4.6</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>21.2</td>
</tr>
</tbody>
</table>

Notes: Dashes indicate that data were not reported. CVD = cardiovascular disease. CHD = coronary heart disease. MI = myocardial infarction. CHF = congestive heart failure.


because of absent symptoms (AHA, 2005). More than two-fifths with diagnosed hypertension are covered by Medicare, and more than one-tenth by Medicaid (National Academy on an Aging Society, 2000b). Because of the lack of sufficient drug and supplementary health insurance coverage, nearly one in five Medicare hypertensive beneficiaries could not purchase the recommended prescription drugs (National Academy on an Aging Society, 2000b). Rates of hypertension are considerably higher in black people than in white people (Table 1) (AHA, 2005). In black people, hypertension is a powerful risk factor for CHD. Also, black people with hypertension are more than twice as likely to suffer health-related work limitations as are black people without it (AHA, 2003).

Risk Factor Disparity, by Race, Ethnicity, and Gender

CVD risk factors include higher cholesterol levels, obesity, inactive lifestyles, unhealthy food, smoking, and diabetes mellitus (AHA, 2003, 2005). The most recent national data on these factors are summarized by race and ethnicity and sometimes by gender in the following sections (Table 2) (AHA, 2005).

Interrelation of Race with SES and Obesity.

CVD-related disparity can be understood only through aging-related SES. Most risk factors tend to increase with age and lower SES because of related unhealthy lifestyles, inadequate nutrition, and distress. In comparison with white Americans, the SES disadvantage of racial and ethnic minority groups is clearly associated with higher levels of these risk factors. Their high prevalence in turn contributes to the higher prevalence of CVD. Among these risk factors, the one most currently worth noting is obesity, as assessed by body mass index, or BMI. This number is calculated by using an individual's height and weight. The BMI standard of overweight in adults is 25 and higher, and that of obesity is 30 and higher. Rates of overweight and obesity are higher in black women and Mexican Americans than in their white counterparts (AHA, 2005), corresponding to their lower SES.

Race Effect on Other Risk Factors and Diabetes.

Ethnic minority groups are also at greater risk levels on some other CVD contributors. Rates of tobacco smoking are higher among American Indians and Alaska Natives than in white men and women (Table 2). The prevalence of total cholesterol levels higher than 200 mg/dL is greater in Mexican American men than in other racial and gender groups except white women (AHA, 2005). However, if the rate of total cholesterol level is compared at a different level (higher than 240 mg/dL), this risk is greater in Asian Americans, Pacific Islanders, American Indians, Alaska Natives, and Hispanics than in both the white and the black population.

Black and Hispanic people, as well as Asian American women, all have higher rates of physical inactivity (Table 2). Finally, a CVD-related health condition, diabetes mellitus, is almost twice as
<table>
<thead>
<tr>
<th>Race and Gender</th>
<th>Overweight and Obesity (%)</th>
<th>Smoking (%)</th>
<th>Cholesterol 200 mg/dL or Higher (%)</th>
<th>Cholesterol 240 mg/dL or Higher (%)</th>
<th>Physical Inactivity (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td></td>
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<tr>
<td>Male</td>
<td>69.4</td>
<td>25.2</td>
<td>51.0</td>
<td>17.8</td>
<td>34.4</td>
</tr>
<tr>
<td>Female</td>
<td>57.2</td>
<td>20.7</td>
<td>53.6</td>
<td>19.9</td>
<td>38.3</td>
</tr>
<tr>
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<td></td>
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<tr>
<td>Male</td>
<td>62.9</td>
<td>27.0</td>
<td>37.3</td>
<td>10.6</td>
<td>45.1</td>
</tr>
<tr>
<td>Female</td>
<td>77.2</td>
<td>18.5</td>
<td>46.4</td>
<td>17.7</td>
<td>55.1</td>
</tr>
<tr>
<td>Mexican American</td>
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<tr>
<td>Male</td>
<td>73.1</td>
<td>-</td>
<td>54.3</td>
<td>17.8</td>
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<tr>
<td>Female</td>
<td>71.7</td>
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<td>44.7</td>
<td>13.9</td>
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<td>Hispanic or Latino</td>
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<td>Male</td>
<td>65.2</td>
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<td>Female</td>
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<td>Total Hispanics</td>
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<tr>
<td>Asian only</td>
<td>34.5</td>
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<td>Male</td>
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<td>Total Asian or Pacific Islanders</td>
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<td>Native Hawaiian or Pacific Islander</td>
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<td>American Indian or Alaska Native only</td>
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<td>American Indians or Alaska Natives</td>
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<tr>
<td>Male</td>
<td>61.7</td>
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<td>Female</td>
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<tr>
<td>Total American Indians or Alaska Natives, Alaska</td>
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<td>Total American Indians or Alaska Natives, Oklahoma</td>
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<td></td>
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<tr>
<td>Total American Indians or Alaska Natives, Washington</td>
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</tbody>
</table>

Note: Dashes indicate that data were not reported.

common in Mexican Americans and non-Hispanic black people as in non-Hispanic white people.

MENTAL HEALTH COMORBIDITY IN RELATION TO CHD HEALTH DISPARITY

CHD, Depression, and Anxiety

Research has indicated an increased prevalence of depression in various CHD conditions, including unstable angina, CHF, MI, and coronary catheterization or angioplasty (Burg & Abrams, 2001; Frasure-Smith, Lesperance, Juneau, Talajic, & Bourassa, 1999; Krantz et al., 2000; Lane, Carrol, & Lip, 2003; Scheidt, 2000; Severus, Littman, & Stoll, 2001; Smith, 2001). Depending on the sample and instrument used, the rate of major depression is estimated at 16 percent to 23 percent; the rate of clinically significant depressive symptoms is estimated at 31.5 percent to 60 percent (Musselman, Evans, & Nemeroff, 1998). Current meta-analyses have linked depressive symptoms or clinical depression with CHD-related mortality, especially three years after an initial assessment (Barth, Schumacher, & Herrmann-Lingen, 2004).

Anxiety has been known as the earliest and most intense emotional response to an ischemic coronary event (Frasure-Smith, 1991). Increasing evidence has associated cardiac problems with anxiety (Lane et al., 2003). A study of MI patients showed more than two-thirds had elevated levels of anxiety and more than a quarter had levels of those seen in psychiatric clinics (Moser & Dracup, 1996). In another study, one-third of 913 patients with unstable angina and MI reported elevated anxiety, and half of them had...
Anxiety has been shown to influence CHD prognosis and mortality (Kubzansky, Kawachi, Weiss, & Sparrow, 1998; Rozanski, Blumenthal, & Kaplan, 1999) and to be an independent predictor for post-MI cardiac events and health care consumption (Strik, Denollet, Lousberg, & Honig, 2003). Anxiety has been shown to influence CHD prognosis and mortality (Kubzansky, Kawachi, Weiss, & Sparrow, 1998; Rozanski, Blumenthal, & Kaplan, 1999) and to be an independent predictor for post-MI cardiac events and health care consumption (Strik, Denollet, Lousberg, & Honig, 2003).

Disparity Evident in CHD-Related Mental Health

Until recently, even less attention has been paid to CVD-related mental health comorbidity in women and ethnic minority groups. For example, negative emotional states, such as anger and hostility, have been related to CHD risk demographics (for example, members of ethnic minority groups, men, and those of lower SES) (Krantz et al., 2000).

Evidence on Disadvantages of Female CVD Patients. Most studies on CVD anxiety are based on male samples (Bankier & Littman, 2002). Compared with men, however, women may have greater risk of anxiety after a cardiac event (Brezinka, Dusseldorp, & Maes, 1998; Frasure-Smith, 1991; Halm & Penque, 2000; Schuster & Waldron, 1991). A 20-year follow-up study indicated anxiety as the predictor of MI or cardiac death among homemakers (Eaker, Pinsky, & CateU1i, 1992). Although women tend to have higher levels of anxiety overall, anxiety-related death is confined mostly to sudden cardiac death in male-only community-based studies (Rozanski et al., 1999).

Of patients with MI or who have undergone cardiac surgery, women are at greater risk of depression or emotional distress than are men (Ai et al., 1997; Con, Linde, Thompson, & Iglaszewski, 1999; Frasure-Smith et al., 1999; Mendes de Leon et al., 2001). Research has shown a poorer post-MI prognosis in women (Czajkowski et al., 1997; Malacrida et al., 1998; Vaccarino, Krumholz, Berkman, & Horwitz, 1995), especially younger women and black women (Vaccarino, Krumholz, Yarzabski, Gore, & Goldberg, 2001; White, Rosamond, & Chambless, 1999). Some gender effects have been attributed to the incidence of MI at an advanced age or MI severity, delayed arrival in the coronary care unit, and less aggressive therapy within the first 28 days (Malacrida et al.; Marrugat, Sala, & Masia, 1998; Vaccarino et al., 1995).

Findings from a National Clinical Trial. A newly published multicenter Enhancing Recovery in Coronary Heart Disease (ENRICHCHD) trial, founded by the National Institutes of Health, has drawn national attention (ENRICHCHD Investigators, 2001, 2003). This clinical trial examined the efficacy of cognitive–behavioral therapy (CBT) in depression and low social support among post-MI patients from a variety of backgrounds. The study established the standard for scientific rigor and enrolled a large proportion of women and members of ethnic minority groups of lower SES. Especially troublesome to the health profession were findings on differential outcomes in relation to health disparity. The results showed that women with MI tend to experience higher levels of depression or emotional distress and reported lower levels of social support than do men (Mendes de Leon et al., 2001).

The ENRICHCHD trial, however, found no survival advantage of CBT on these patients (ENRICHCHD Investigators, 2003). Additional data analyses showed more alarming disparities. A more recent report from this study suggested that CBT and social support contributed to reduced levels of depression and an increase in perceived social support among all groups in the large sample (Schneiderman et al., 2004). Nonetheless, this intervention had only a marginally positive effect on medical endpoints in white men, no effect in white women and ethnic minority men, and even a marginally negative effect in ethnic minority women. In addition, white men were younger and healthier and had greater social support. After adjusting for these and other factors (for example, antidepressant use, depression, and cardiac index), disparity on medical endpoints was still present.

Aftermath Considerations Following Major Clinical Trials. Another large-sample trial on home-based psychosocial nursing intervention for post-MI patients found no overall survival impact but higher cardiac and all-cause mortality among women (Frasure-Smith et al., 1997). Participating nurses all had cardiac care experience but no specialized mental health training. Particularly disturbing was the great incidence of mortality from arrhythmia among treated women. The investigators suggested that the intervention might induce harm by reminding them of the MI and activating distress or anxiety. The lack of mental health consideration in intervention with female MI patients could be considered a risk factor. In addition, a smaller clinical trial on cardiac rehabilitation patients showed that men benefited more from physically active.
lifestyles (Rejeski, Brawley, Amrosius, Brubaker, & Fox, 2003).

On the basis of the disappointing findings on established CBT for MI patients' survival, the ENRICHD investigators have noted the likely lower motivation of disadvantaged people (ENRICHD Investigators, 2003) and better utilization of cardiac procedures by white men (Schneiderman et al., 2004). For future research, they pointed to investigation of other factors, such as emotion, arousal, and increase in self-efficacy, coping, and other aspects of social support (ENRICHD Investigators, 2003). However, CBT or other psychological interventions are mainly based on the mainstream culture and do not consider the fundamental differences in socioenvironmental factors affecting different social strata. These strategies are likely insufficient to improve cardiac outcomes for those who are disadvantaged if their basic socioeconomic and spiritual needs are unmet. Clearly, more culturally and gender-sensitive psychosocial research and interventions are needed to improve cardiac health disparity.

**IMPLICATIONS FOR SOCIAL WORK**

Evidence has suggested that the mental health and social needs of CVD patients remain largely unmet, especially for women, ethnic minority groups, and socioeconomically disadvantaged populations. Social workers in health, mental health, and gerontological care must assume new responsibilities in preventive and clinical cardiac care (Anderson et al., 2001; Proctor et al., 2000; Sulman & Verhaeghe, 1994; Thurlow, 1995). Because many social workers do not have substantive knowledge regarding CVD, psychosocial training in cardiac care is needed (Frasure-Smith et al., 1997).

**Professional Practice Recommendations**

In addition to standard social services offered to the general population, social workers must develop their professional models to address the pressing issues of the CVD population and methods that are effective with older, minority, and disadvantaged populations.

**Assessment of Clients with CVD or at Risk of CVD**. CVD-related risk factors such as obesity, physical inactivity, smoking, menopause, and lack of social support should be identified. To reduce the ongoing effect of these risks, family members should be interviewed to determine their understanding of prognoses and care needs and their ability to support the patient. Existing involvement with community agencies and need for additional support to meet basic living and medical requirements should also be evaluated.

Assessment should also involve socioeconomic concerns, medical compliance, and access to health care and medical funding. This includes prescription drug coverage, daily activity level, functional disabilities, adjustment to illness, financial resources, legal issues of competency, advance directives, and durable power of attorney for health care.

Given the protective role of spirituality and positive expectations in cardiac care, social workers should be attentive to the patient's mental resources, such as optimism, hope, self-efficacy, adaptive coping styles, and a sense of spiritual support (Ai, Park, Huang, Rodgers, & Tice, in press; Ai, Tice, Peterson, & Huang, 2005). Spiritual resources, which include all sources of hope, strength, and purpose, as well as possible religious affiliation, enhance the meaning of life and connectedness to counterbalance CVD-related distress (Ai, Peterson, Tice, Huang, Rodgers, & Bolling, in press). Spiritual assessment tools have been developed to aid practitioners in understanding patients' deepest beliefs and values (Anandarajah & Hight, 2001; Fallot, 1998).

**Actions for CVD-Related Disparity.** Key aspects of addressing the health disparity issues associated with CVD include greater professional endeavor to enhance cultural competence and educate the multidisciplinary team about these health disparities. Social workers must incorporate culture-sensitive risk assessment and interventions into health care for older, female, and ethnic minority CVD patients (Galambos, 2003; Panos & Panos, 2000). Social workers need to obtain cardiac and self-care information about diverse populations and understand the particular socioeconomic, cultural, and political environments that directly affect the incidence of CVD. Community and policy practice for systems change is needed. For instance, traditional risk factors in the disproportionately high incidence of CHD among native Hawaiians were found to be compounded by barriers in the health care system (Mokuau, Hughes, & Tsark, 1995). The high cost of medical care, isolated communities, and lack of culturally compatible practitioners with knowledge of indigenous healing practices reduced the acceptability of health services. Culturally responsive strategies such as communal decision making and
incorporation of traditional foods enhanced disease management in this population.

Prevailing medical models may pathologize culturally based behaviors or view discrimination-related anger, hostility, and distress—known CVD risks—as personal problems. Medical social workers must educate their teams about institutionalized oppression and barriers to care, as well as cultural value conflicts that may negatively influence clinical practice. To improve motivation and compliance in ethnic minority patients, education should include the development of communication skills and models of practice that adequately demonstrate respect for cultural orientation, primary language, and level of acculturation. The effect of historical trauma and racism on CVD and the positive role of patients’ beliefs about health, disease, service use, and culture-bound healing systems must be acknowledged. Patients should be encouraged to lend their voices to the national debate about equal access to health care for all.

Enhance Family Care for CVD. Finally, to integrate existing professional strengths into family-oriented care for the two CVD-related gaps, we recommend additional key services, such as counseling and support for caregivers, referrals for adequate home care services, and assistance with late-stage care and advance directives. Social workers must include families in treatment planning not only as therapeutic allies, but also in regard to the multiple stresses that caregivers experience (Lim & Zebrack, 2004). CVD, especially MI and stroke, can cause sudden and permanent disability in previously healthy people, leaving unprepared families in devastation. Assessment of family members should include the effect of shifting roles and responsibilities; disruptions in their health, income, and quality of life; and other stressors such as the degree of caregiving demands and overload, patient impairment, ADL dependency, and the need for additional assistance.

Mortality and morbidity following some CVD incidents are reversible, if appropriate procedures are implemented immediately. Social workers can help family members consider effective strategies for CVD patients to respond to a disabling emergency. For elders living alone, the use of medical alert systems that contact neighbors or the 911 service in case of stroke or acute MI is extremely effective.

Because CVD hospitalization creates major costs, the key to preventing readmission lies in the quantity and quality of home care supports. Identification of a helper or community service programs should be recommended as necessary to assist with specific ADLs, chores, meals, or medication management. In addition to home nursing and therapy services, the involvement of extended families and community or church supports is vital, especially for patients of color and members of tribes who have collective family values.

Social workers should ensure that patients and their families understand the eligibility criteria for hospice or palliative care in the face of a terminal diagnosis and assist older and ethnic minority CVD patients in voicing their questions regarding any recommendation to end aggressive care. Ethnic minority clients, who may be mistrustful due to historical trauma and discrimination, may respond more positively to newly developing cultural mediation and specialty care programs in their own communities.

Advance planning for expected further deterioration or a terminal event can help preserve dignity and clarify patients’ wishes. Special attention should be paid to CVD patients with depression, low social support, and spiritual or religious needs (Ai, Hopp, & Shearer, 2006). A discussion about health care directives or funeral planning can be linked to the value of self-determination, which is most effective when not crisis driven.

With such efforts, social workers can play a frontier role in improving CVD-related comorbidity and disparity and in promoting better quality of life for patients and their families.

REFERENCES


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