

# African Americans and Heart Disease

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Good health depends on multiple factors, including financial status. Higher socioeconomic status correlates with a lower risk of cancer, diabetes, and heart disease. [Lukachko, Hatzenbuehler, and Keyes \(2014\)](#) stated that the advantages of income status make a difference with health, specifically heart disease. Another significant factor affecting heart disease is health care disparity. [Kahng \(2010\)](#) found that the accumulative impact of health care disparities experienced over a lifetime contributes to chronic stress and heart-related problems.

Despite advancement in care, more African Americans, compared with other racial groups, die from cardiovascular disease ([Centers for Disease Control and Prevention \[CDC\], 2016](#)). Several risk factors are directly related to heart disease. Cardiovascular disease includes diseases of the heart and blood vessels, stroke, coronary heart diseases, high blood pressure, high cholesterol, and congestive heart failure. Atherosclerosis, hypertension, and congenital heart defects are other forms of cardiovascular disease ([American Heart Association \[AHA\], 2016](#)). [Savitz \(2012\)](#) cited disparities in cardiovascular health care as one of the most crucial public health problems in the United States.

## HEART DISEASE AND RACIAL AND ETHNIC DIFFERENCES

African Americans are at a higher risk of dying from heart failure, regardless of the patient's disease severity or symptomatic state. African American patients have a 25 percent higher risk of dying from heart disease than do white non-Hispanic patients ([CDC, 2016](#)). Often, a delay in seeking medical treatment increases the likelihood of dying from heart disease ([AHA, 2016](#)). [Lukachko et al. \(2014\)](#) reported that cardiovascular diseases account for one-third of the differences in life expectancy between black and other racial groups, and African Americans are slower to receive specialized care including coronary artery bypass graft surgery ([CDC, 2016](#)).

African Americans face disadvantages in multiple societal areas such as educational attainment, employment, income, voter registration, and incarceration. Unintentional racial disparity presents in different ways, including lack of respect by the medical profession. Health care practitioners and clients have individual cultural backgrounds that guide their health care perceptions. [Lukachko et al. \(2014\)](#) noted that racial disparity exists across health care domains in the United States.

Health care professionals, including social workers, must be aware of preconceived views and have an understanding of cultural backgrounds, life experiences, and geographical regional influences that may affect services delivered to different ethnic groups ([Savitz, 2012](#)). Education within health care needs to include a cultural sensitivity component to increase awareness and improve racial and health care disparities. Only 10 percent of physicians and registered nurses are American Indian, African American, or Hispanic ([U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis, 2015](#)).

The different racial and ethnic population attitudes and social constructs of decision making are often expressed unintentionally and, consequently, may be difficult to control in health care settings. However, the patient-provider relationship greatly affects patient outcomes ([Savitz, 2012](#)). Health disparities exist for underserved, marginalized, lower socioeconomic level groups and affect heart disease mortality of the African American population.

The high rates of cardiovascular disease among African Americans are influenced by several determinants, risk factors, traits, and lifestyle habits including medication compliance. However, compliance depends on a positive relationship between patients and their health care providers. Warmth, empathy, and genuineness have been proven to increase compliance with multiple medical interventions ([Viswanathan & Lambert, 2005](#)).

If not presented in a meaningful manner, medical recommendations will often not be followed (Savitz, 2012).

Risk factors for heart disease also include the following:

- Blood pressure: High blood pressure increases the risk of heart disease.
- Tobacco use: Nicotine narrows blood vessels, which can lead to high blood pressure.
- Cholesterol level: High cholesterol increases the amount of fatty buildup in the arteries.
- Obesity: Being overweight causes the heart to work harder.
- Physical activity: Being inactive increases the chances of becoming overweight.
- Diabetes: High blood sugar increases the rate of atherosclerosis.
- Stress: High stress is a significant risk factor for chronic health conditions.

Due to identified risk factors, it is important that African Americans improve their diets and manage the risk factors that they control (CDC, 2016).

Self-efficacy, one's belief to achieve a certain goal, is another factor for cardiovascular disease treatment and can empower patients making positive health behavior changes (Viswanathan & Lambert, 2005). There are specific steps that African Americans and other at-risk groups can take to mitigate the effects of risk factors. Awareness, and treatment, of cardiovascular disease by African Americans is critical. Interventions include, but are not limited to, the following:

- Frequently monitoring blood pressure and cholesterol levels
- Reducing the amount of fat and cholesterol in daily diets
- Replacing fried foods with more baked foods
- Ceasing smoking and using other nicotine products
- Managing diabetic glucose with efforts to keep blood sugar levels in normal range
- Complying with medication use as prescribed by physicians
- Reporting medication side effects immediately to prescribing physicians
- Exercising at least 20 minutes three times per week and reducing stress

## SUGGESTIONS AND RECOMMENDATIONS

Because African Americans are more likely to report health care disparities, isolation, and lack of care, improving access to health care by expanding community-based health centers is essential (CDC, 2016). Social work has long been the collaborative leader with culturally competent health care providers. In addition to required social work licensure ethics training, some states require culture diversity education for licensure renewal. Health care social workers have a long history of helping isolated and oppressed populations.

Social workers have embraced the preventive approach in both mental and physical health, having led the charge with devoted efforts for vulnerable, oppressed populations and advocating for health promotion endeavors (Aschbrenner, Bartels, Mueser, Carpenter-Song, & Kinney, 2012). When health care teams including social workers displayed genuine concern for their patients, patients were more likely to follow through with medical recommendations. These patients tend to seek medical interventions for chronic conditions such as hypertension, diabetes mellitus, elevated cholesterol levels, and obesity (Viswanathan & Lambert, 2005). Increased support from social networks improves a sense of wellness, social health, and the likelihood of seeking early medical care (Kahng, 2010).

## ADDRESSING HEALTH FACTORS OF MARGINALIZED POPULATIONS

Impoverished conditions and lack of opportunity create multiple societal and health care challenges. Lukachko et al. (2014) found that residing in a disadvantage neighborhood leads to a 50 percent to 80 percent increase in the risk for heart disease. People living in poverty face increased worry and anxiety about crime, higher unemployment, substandard housing, lack of reliable transportation, and fewer healthy food choices. All of these situations have a negative and toxic effect on health. Because extreme poverty has increased, one of the essential predictors of health care disparity is socioeconomic level. Accordingly, adequate income is needed to maintain a healthy lifestyle (Kahng, 2010).

Community awareness regarding the high rate of heart disease and education about controlled and noncontrolled risk factors while addressing cultural health care disparities within the medical profession are essential. Certain city neighborhoods are often

poverty ridden, marginalized, and isolated. Taking services and outreach efforts to these communities is imperative because health care must be accessible and approachable. Social workers engaged in evidence-based health promotion models make health care more personable through the person-in-environment approach. Examples include social workers at obstetric clinics. The staff offered at-risk clients a party with gifts of diapers, pacifiers, strollers, car seats, baby food, and so on, if the client kept all her prenatal appointments. Because dental hygiene is closely tied to physical health, another creative example is an academic mobile dental clinic that provides dental care to more isolated, poverty-ridden neighborhoods.

Many African Americans underestimate their perceived cardiac risk, specifically if they are single, and need encouragement to become proactive in a healthy lifestyle (Lukachko et al., 2014). Health and nutrition classes offered through neighborhood centers reduce the impact of cardiovascular disease. Understanding risk and medical interventions is a major part of medical education for these underserved communities. People living in deep poverty do not have access or resources for technology or Internet services (Aschbrenner et al., 2012). Developing creative approaches along with support and encouragement from community social workers increases the opportunity to connect with health care professionals. Another innovative example is hospitals in the more impoverished cities in the United States that assigned a social worker to the most poverty-stricken ZIP code area to address health disparities. These are all examples of improving health outcomes for isolated communities.

Isolated communities are not aware of vital and reliable health promotion and disease prevention measures. Social workers have the opportunity to develop strategies for helping at-risk individuals engage in healthy habits and develop family support. Even if most communities are aware of basic health information regarding exercise and healthy diets, implementation is an additional challenge. Social workers, health care professionals, and family members help nurture healthy habits and behaviors over a lifetime. Social workers have long identified the need for increasing self-worth, establishing meaning and purpose in life, enhancing the ability to develop social supports, and buffering against marginalization while addressing social justice. Health promotion actions led by social workers can help people commit to making at least one

positive lifestyle change (Lawrence & Radwan, 2014). With education, assistance, and family psychoeducation, risky behaviors can be transformed into healthy choices. **HSW**

## REFERENCES

- American Heart Association. (2016). *Heart and stroke statistics*. Retrieved from <http://www.heart.org/HEARTORG/General/Heart>
- Aschbrenner, K., Bartels, S., Mueser, K., Carpenter-Song, E., & Kinney, A. (2012). Consumer perspectives on involving family and significant others in a healthy lifestyle intervention. *Health & Social Work, 37*, 207–215.
- Centers for Disease Control and Prevention. (2016). *Public health action plan to prevent heart disease and stroke*. Retrieved from [http://www.cdc.gov/dhdp/action\\_plan](http://www.cdc.gov/dhdp/action_plan)
- Kahng, S. K. (2010). Can racial disparity in health between black and white Americans be attributed to racial disparities in body weight and socioeconomic status? *Health & Social Work, 34*, 257–266.
- Lawrence, W., & Radwan, H. (2014). The impact of e-health on cardiac health education among African Americans. *i-manager's Journal on Nursing, 4*(1), 4–8.
- Lukachko, A., Hatzembuehler, M. L., & Keyes, K. M. (2014). Structural racism and myocardial infarction in the United States. *Social Science & Medicine, 103*, 42–50.
- Savitz, S. T. (2012). Literature-based appraisal of racial/ethnic cardiovascular health care disparities. *International Scholarly Research Notices: Public Health*. Article 235921. doi:10.5402/2012/235921
- U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis. (2015). *Sex, race, and ethnic diversity of U.S. health occupations (2010–2012)*. Rockville, MD: Author.
- Viswanathan, H., & Lambert, B. L. (2005). An inquiry into medication meaning, illness, medication use, and transformative potential of chronic illness among African Americans with hypertension. *Research in Social and Administrative Pharmacy, 1*(1), 21–39.

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