

PANEL SUMMARY

PANEL SUMMARY: SOCIAL, CULTURAL AND PSYCHOSOCIAL DETERMINANTS OF CARDIOVASCULAR DISEASE/HEALTH

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SUMMARY

This panel discussed the importance of considering non-traditional risk factors as independent contributors to cardiovascular disease (CVD) in the African American (AA) population. Based on published and unpublished results, the panel concluded that more recent research has shown that factors, such as perceived stressors, socioeconomic status (SES), and neighborhood environments (in addition to traditional biomedical risk factors), are associated with increased risk of CVD among AAs.^{1,2}

One Jackson Heart Study (JHS) publication examined the association between multiple measures of perceived discrimination with prevalence of hypertension in AAs.³ Hypertension prevalence was greater among women than men in the JHS (64.0% vs 59.7%, respectively). Lifetime discrimination was associated with hypertension prevalence, and burden of lifetime discrimination attributed to racial status was associated with hypertension prevalence. Other research presented reported that perceived discrimination was associated with health behaviors, such as smoking, diet and physical activity, among JHS participants. Health behaviors may be coping responses to

experiences of discrimination among AAs.⁴ Similar research showed that reports of perceived everyday discrimination were positively associated with visceral fat in a sample of AA and Caucasian women.⁵ Overall, findings showed that more understanding should be given to the role of reports of perceived discrimination in order to understand disparities in hypertension, behavioral risk factors and obesity and fat distribution.

In addition to psychosocial stressors, social epidemiologists must also focus on the role socioeconomic status (SES) plays in the understanding of CVD disparities and related risk factors in the AA population. The social patterning of CVD and related risk factors may reveal the extent to which high social position provides a protective buffer against CVD and related risk factors. Findings showed that there was an inverse association between SES (education, income and occupation) and diabetes prevalence.⁶ Other research showed that the odds of having chronic kidney disease (CKD) were 41% lower for affluent men and women than their less affluent counterparts.⁷ Because persons with lower SES had greater prevalence of diabetes and CKD than higher SES counterparts in the JHS, efforts to reduce diabetes and CKD disparities between racial and ethnic

PANEL SUMMARY: PSYCHOSOCIAL DETERMINANTS OF CVD

groups may need to focus on risk factors among lower-status AAs in the JHS. In addition to the individual-level measures of SES, research has also focused on the neighborhood environments in which participants live in order to consider how the environmental context interacts with individual-level SES, psychosocial factors and traditional biomedical risk factors. This ecological approach considers individuals in the context of their physical environment and how it contributes to CVD disparities. One panelist found that neighborhood socioeconomic disadvantage in the JHS was associated with the metabolic syndrome, components of the metabolic syndrome and measures of cardiovascular inflammation.

Findings from the JHS can increase our understanding of CVD disparities using psychosocial and ecological approaches. At the same time, the JHS engages the community where results are disseminated and future interventions may be developed from the perspective of not only the scientist or clinician, but from the participant as well.

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