Osteoporosis is a major public health concern because of the subsequent disability, diminished quality of life, and high mortality rates for those afflicted, according to the World Health Organization (1999). The perception that osteoporosis is an older person’s disease, however, is an erroneous one. Osteoporosis does not discriminate by age, according to the National Osteoporosis Foundation (NOF, 2007). It is important that health social workers be alert to the early onset of this debilitating disease that affects clients of all ages.

Osteoporosis has been described as a geriatric disease with an adolescent onset. In fact, strategies to prevent adult osteoporosis are best undertaken during childhood and adolescence, when the greatest amount of bone mineral density is acquired (Fleming & Patrick, 2002). Since notable established risk factors associated with developing the disease include increasing age, being female, and removal of the ovaries at an early age (Kelsey, 1989), early education and identification of general health risks are imperative, particularly for both younger and older women.

**Biomedical Dimensions**

Osteoporosis—or porous bone—is a skeletal disease characterized by loss of bone mass resulting in an increased risk of fractures (especially to the hip, spine, and wrist) with associated morbidity and mortality (McDonagh, 2001). According to NOF (2007), osteoporosis is a “silent thief” because it often goes undetected until a person experiences severe back pain, loses height, or falls and breaks a bone. The disease threatens an estimated 44 million Americans—55 percent of those 50 years and older—resulting in an estimated 1.5 million osteoporotic fractures annually in the United States and nearly $18 billion per year (in 2002 dollars) in health care costs (NOF).

A woman’s risk of hip fracture is equal to her combined risk of breast, uterine and ovarian cancer. In severe cases, fractures can result in permanent disability, which can lead to loss of independence and even death for some sufferers. Twenty-four percent of individuals who sustain a hip fracture in the United States die within a year of the fracture (NOF, 2007). The physical ramifications of vertebral fractures often result in stooped posture, decline in height, and chronic pain and disability. Osteoporosis can often cause compression on the lungs and stomach. As a result, people tend
January 4, 2007 was the beginning on the newly elected, Democratic controlled Congress. With Representative Nancy Pelosi (D-CA-38) as the first woman Speaker of the House and Senator Harry Reid (D-NV) as the new Majority Leader in the Senate, the 110th Congress is off to a great start. With 2006 election cycle being titled the “Year of the Woman,” this Congressional class represents a more diverse class than ever before. Below, please see the ethnic diversity breakdown of the 110th Congress:

**African-Americans serving in Congress:**
One African American in the US Senate
41 in the House of Representatives

**Women:**
16 women in the US Senate
74 in the House of Representatives (10 are freshman)

**Hispanic Americans:**
3 Hispanic Americans in the US Senate
22 in the House of Representatives

**Asian Americans:**
2 Asian Americans in the US Senate
5 in the House of Representatives

**Indian American:**
1 Indian American in the US House of Representatives

Also, this past election cycle, two additional Social Workers were elected into federal office. We now have 10 Social Workers who currently serve in the United States Congress – 8 in the US House of Representatives and 2 in the United States Senate:

**Senators:**
Barbara Mikulski (D-MD)
Debbie Stabenow (D-MI)

**Congressmen/women:**
Ed Towns (D-NY-10)
Barbara Lee (D-CA-9)
Susan Davis (D-CA-53)
Allyson Schwartz (D-PA-13)
Ciro Rodriguez (D-TX-23)
Carol Shea Porter (D-NH-1)
Luis Gutierrez (D-IL-4)
Stephanie Tubbs Jones (D-OH-11)

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to significantly restrict their movement and mobility, which can contribute to isolation and deterioration in their overall health and well-being.

*Primary osteoporosis* occurs when there is a problem within the bone itself and includes Type I (postmenopausal), Type II (elderly women and men), and Idiopathic (adult and juvenile). Type I occurs in women during the early years after natural or surgically induced menopause due to decreased levels of estrogen, which helps convert calcium to bone. *Secondary osteoporosis* is bone loss due to other diseases or adverse effects of drug therapy, including psychotropic medication (Fitzpatrick, 2002).

Despite considerable debate regarding the etiology of osteoporosis, the current consensus in the literature suggests that adequate calcium intake, weight-bearing exercise and vitamin D are useful preventive strategies (Fitzpatrick, 2002). Although there is no known cure for osteoporosis, medication is typically prescribed. However evaluating pharmacological options such as hormone replacement therapy can be difficult for both physicians and patients due to insufficient data, conflicting findings, and the reality of ever-changing biomedical knowledge. (Fitzpatrick).

**Biopsychosocial Dimensions**

Young women are bombarded by mass media messages that portray the ideal woman as model-thin, buff, glamorous, and sexy. These images—combined with the intense yearning of many young girls to be liked, loved, and popular—lead some to adopt harmful lifestyles and high-risk behaviors, such as smoking and excessive athleticism, increasing their chances for osteoporosis and other health problems. The *female athlete triad* is a condition seen with increasing frequency in young athletes and characterized by the triple threats of amenorrhea (menses cessation for six months or more), disordered eating, and osteoporosis (Golden, 2002). Moreover, osteoporosis is one of the most serious and potentially disabling medical complications of anorexia nervosa (Wolfert & Mehler, 2002). Since weight-bearing physical activity and greater calcium intake serve as protective factors in the development of peak bone mass (Wallace & Ballard, 2002), proper diet and exercise are preventive measures against osteoporosis in later life.

Adult women face many of the same challenges as their younger counterparts, but also experience unique biopsychosocial processes. There is a rise in premature menopause affecting women in their twenties, thirties, and forties, placing them at greater risk of osteoporosis (Petras, 1999). Women experiencing perimenopause (changes that will lead to menopause, such as irregular bleeding and changing hormone levels) or having stopped menstruation altogether, often face the difficult challenge of battling negative social views of midlife. Negative perceptions about aging, coupled with a diagnosis of osteoporosis, can result in a lower quality of life for many women (Bayles, Cochran, & Anderson, 2000). Counseling interventions aimed at treating depression are of utmost importance, as depression appears to be a risk factor for osteoporosis. Decreased bone mineral density (BMD) is more frequently seen in people who are depressed than in the general population (Cizza, 2006).

For working-age women, a sedentary lifestyle and a lack of time appear to be significant constraints such that the Surgeon General’s Report sanctioned future research on workplace policies that support women’s efforts to be more physically active (Eyler, Brownson, King, Brown, Donatelle, & Heath, 1997). Older adults may find it particularly difficult to begin an exercise regimen for the first time later in life. Homebound adults who receive inadequate sunlight exposure, and subsequently decreased vitamin D, are at particular risk of the disease.
What Social Workers Can Do

Social workers across practice settings are in prime positions to address both risk factors and assist with disease management. Along with their medical colleagues, social workers can educate parents that healthy eating patterns should be developed as early as infancy and early childhood (Kleerekoper, 1998). Social workers should assess the dietary habits of their female clients and be alert to the potential adverse risk of osteoporosis from use of psychotropic medications. Since weight-bearing physical activity and calcium intake serve as protective factors in the development of peak bone mass, young women need to be encouraged to maintain an active lifestyle and consume the recommended dosage of calcium. School social workers can intervene with individual counseling and program development efforts that educate students on mental and physical health topics such as body image, self-esteem, nutritional habits, eating disorders, smoking, alcohol, and exercise. Furthermore, university health centers are an ideal setting to address primary prevention since opportunities for osteoporosis prevention are limited after the college years as attention becomes focused on disease treatment (Leslie & St. Pierre, 1999).

For individuals newly diagnosed with osteoporosis, the focus shifts to assisting clients and their loved ones in coping with the diagnosis, adapting to the illness, and limiting the progression of symptoms. Multiple psychosocial and quality-of-life issues are associated with osteoporosis, including anger, depression, anxiety, negative self-esteem, pain, insomnia, and fear of falling (Bayles et al., 2000). Use of standardized health-related quality-of-life questionnaires, such as the Quality of Life Questionnaire (Cook et al., 1999) and the 36-item Short Form Health Survey (SF-36) (Berkman et al., 1999), can provide early assessment of chronic illness and its functional consequences and psychosocial sequelae in patients.

Finally, interventions become more intensified in an effort to minimize its effects for women living with the full impact of osteoporosis. Social work practitioners in hospitals, home health care agencies, and nursing homes can provide psychoeducation about health and wellness and supportive counseling in the management of chronic illness. Interventions to assist with chronic pain management become even more significant as pain often forces women to withdraw from social activities and interferes with sleep patterns, household tasks, and recreational activities (Roberto & Reynolds, 2002).

Case management interventions including assessment of client nutrition intake and referral to nutritionists for dietary recommendations and home-delivered meal programs can be implemented. Social workers should consult with medical, nursing, and physical therapy colleagues to determine in-home exercise programs, home care equipment needs such as a cane or walker, and needed housing modifications. Referrals to peer support groups may also be effective for some osteoporotic women (Bayles et al., 2000). The NOF has been the leader in the development of a national support group network called “Building Strength Together” for people afflicted with this disease (http://www.nof.org). The progression of the disease necessitates that social workers assist clients in educating and mobilizing informal social supports, such as family and friends (Roberto & Johnston, 1991). Social support services for caregivers and the positive aspects of caregiving should also be addressed (Ross, Holliman, & Dixon, 2003).

Social workers provide vital services to improve patient quality-of-life outcomes and increase the value of the health care dollar in health systems and managed care settings (Claiborne & Vandenburg, 2001). The financial costs of osteoporosis are enormous; however, the most extensive costs derive from the individual’s suffering, deformity, and disability (Bayles et al., 2000). It bears repeating that osteoporosis is not solely an “elderly person’s disease.” The reality is
that females in their early twenties have osteoporosis as a result of anorexia and premature menopause. Culturally relevant prevention and intervention efforts should target women across the lifespan in a variety of practice settings. In addition, future research should address osteoporosis in boys and men as millions of affected males are undoubtedly of utmost concern and worthy of study. It is no simple task to convince individuals that preventive health measures early in life can significantly reduce the risk of this debilitating disease that may not manifest itself for another 40 years or more. Early intervention is critical so that the insidious intrusion of this silent thief is made known, and the vitality of women’s bodies is preserved.

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REFERENCES


LIVING WITH PARKINSON’S DISEASE—HOW SOCIAL WORKERS HELP

Christina Erickson, LISW, PhD

Parkinson’s disease (PD) is the second most common neurodegenerative illness after Alzheimer’s disease, affecting more than one million individuals in the United States. Parkinson’s occurs more often in older people than in young, though cases have been reported in people as young as their 20s. The average age of diagnosis for the disease is 60.

Parkinson’s disease is a disease of the nervous system. The nervous system is made up of cells and tissues, including the brain, spinal cord, nerves, and nerve centers, which coordinate and control the body’s responses.

Diagnosis and Symptoms
The symptoms of Parkinson’s disease include rigidity, tremors, loss of balance, and slowness of movement. The disease progresses slowly, and no known cure exists. Also, no test exists that can conclusively identify Parkinson’s disease. Instead, diagnosis is made as the set of symptoms appears, often over a period of up to two years. Doctors who specialize in diagnosing and treating Parkinson’s disease are neurologists, who have advanced training as movement disorder specialists.

The symptoms of Parkinson’s disease are classified into the following five stages identified on the Hoehn and Yahr scale (National Institutes of Health, 2006) and characterized by the following:

**Stage one**
- Signs and symptoms on one side of body only
- Symptoms mild
- Symptoms inconvenient but not disabling
- Usually tremor of one limb
- Changes in posture, locomotion and facial expression

**Stage two**
- Symptoms are bilateral
- Disability minimal
- Posture and gait affected

**Stage three**
- Significant slowing of body movements
- Impairment of equilibrium in walking or standing
- Generalized dysfunction, moderately severe

**Stage four**
- Symptoms severe
- Ability to walk limited
- Rigidity and bradykinesia (slowness of movement)
- Inability to live alone
- Tremor may be less than earlier stages

**Stage five**
- Cachectic stage (total disability, requiring complete nursing care)
- Invalidism complete
- Inability to stand or walk
- Nursing care required

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How Social Workers Help

• Consider the Client as Partner
  Respecting the client as a partner encourages an open dialogue that will help illuminate all areas that may be affecting the client’s life. For example, the person with Parkinson’s should have an agreed upon health plan developed with her or his full participation. Such a plan addresses the individual’s unique issues and responses to medication, as well as exercise, careers, telling family and friends, nutrition, and coping emotionally with a chronic illness.

• Identify and Address Reasons Why Clients Are Not Taking Medications Appropriately
  Medication non-adherence (not taking one’s medications as instructed) has immediate physical effects for people with Parkinson’s. Falling, increased tremors, and stiffness are just some of the symptoms a person can experience if even one dose is missed. Such immediate effects are rarely seen in other chronic diseases. Thus, addressing medication non-adherence is particularly important in Parkinson’s disease.

  Social workers should encourage clients to keep a detailed log of medication use, symptom repression, side effects, and barriers to taking the medication as prescribed. This log will help clients clearly describe their experiences to their physicians, and will provide a basis for a true partnership. Social workers should also provide access to resources like timers and pill boxes, coordinate help from a care-partner as needed, and address other barriers to medication adherence, such as lack of transportation or insurance coverage.

  Medications to treat Parkinson’s disease can be very expensive. When choosing a Medicare Part D plan, social workers must consider program formularies to assure maximum coverage for medication costs.

• Educate Clients
  Educational information, seminars, conferences, and recreational events are sponsored by the Parkinson’s organizations listed below. It is important to inform clients of their options for education, and to encourage their participation in events that feel comfortable to them.

• Encourage Participation in Support Groups
  The power of support groups cannot be overlooked in the process of addressing living with a chronic illness. Social workers can facilitate support groups for clients or provide the context in which self-help groups can be developed. The organizations listed below have existing support groups in various parts of the United States.

• Provide Coordination to the Multi-Disciplinary Team
  Parkinson’s disease affects various aspects of an individual’s life. Providing comprehensive care requires coordination of a multi-disciplinary team of professionals. Social workers are the natural coordination point for these multi-disciplinary teams, which can include: neurologists, psychiatrists, physical therapists, nurses, pharmacies, clients, and care partners. Ensuring communication between team members and thus maximizing support services, can ensure a full and active life for people with Parkinson’s.

Client Services and Support

Specialty clinics are available in various parts of the country to treat patients with Parkinson’s disease. The National Parkinson Foundation and the American Parkinson’s Disease Association are the largest organizations helping people with Parkinson’s. Both organizations serve clients in a variety of formats, including specialty clinics, support groups, educational events for professionals and clients, and educational literature.

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Anorexia nervosa is widely thought of as a “women’s disease.” In reality, this is not the case. In fact, the first documented clinical case of anorexia was a male (Ray, 2004). Currently, men account for only about 10 percent of people with anorexia, but the occurrence of this disorder among males has increased in recent years (Modan-Moses & Yaroslavsky, 2002).

Researchers estimate that as many as one-third of women and 15 percent of men in the U.S. population will have an eating disorder (ED) or related problems at some point in their lives (Cumella, 2002). Body dissatisfaction, socio-cultural pressure to be thin, and the body mass index are all factors that have been reported to contribute greatly to the increasing number of eating disorders occurring in Western societies (Stice, 2001).

Men with EDs

Previous research showed that when men are dissatisfied with their bodies, they are more likely to want to increase their size (Tiggeman & Wilson-Barret, 1998). Although one-third of adolescent males want larger, more muscular bodies, according to Ricciardelli (2003), another estimated one-third of adolescent males want their bodies to be thinner. The number of adolescent males reported to be engaged in strategies to gain body weight is estimated at 21.2 to 53.8 percent, while the number of adolescent males engaged in weight loss strategies is estimated at 21.5 to 50 percent (Ricciardelli, 2003).

Similarities in the symptomology, course, and outcome of eating disorders among men, when compared to women, have been consistently recognized among clinicians (Hsu, 1990; Woodside, Garner, Rockert, & Garfinkel, 1990). Andersen (2001) reported sound gender neutrality in reference to a bulimia nervosa diagnosis. However, more research into understanding and treating eating disorders in men is necessary.

Differences Between Men and Women with EDs

Unlike the issue of women and eating disorders, little research has been done on males and eating disorders. Cumella (2003) found in his research on males with eating disorders that there are several etiologic differences when compared to women with eating disorders, including the following:

- Many men with EDs are actually obese. Obesity is not merely self-perceived, as in many females with EDs.
- Men with EDs often diet to achieve a stereotypical, mesomorphic shape, fantasizing that they will feel more masculine, in control, and respected if they achieve this idealized body.
- Men with EDs appear to have more gender identity struggles than do women with EDs. The ED may be an effort to suppress this internal conflict, or to resolve it by seeking a stereotypical masculine body shape. However, these gender-identity issues do not correlate directly with, and should not be confused with, sexuality or sexual-orientation issues.
- Males with EDs are reported to have lower levels of sexual activity than other males. Schiltz (2005) reported that males with EDs display a significant level of anxiety relating to sexual activities and relationships.
- It is unclear whether men with EDs are more likely to be gay. Some research shows that homosexuals are over-represented in samples of men with ED (Schiltz, 2005).
- Males with anorexia evidence more extreme obsessiveness than females with anorexia.
- Males with bulimia evidence more extreme impulsivity than females with bulimia.
- Men with EDs sometimes diet to avoid medical complications, especially those experienced by their fathers.
- Men with EDs often belong to weight-sensitive subgroups. Andersen, Bartlett, Morgan, and Brownell (1995) reported that gymnasts, runners, body builders, rowers, wrestlers, jockeys, dancers, and swimmers are more susceptible to developing EDs because their
sports demand weight restriction.

- Males with EDs report less sexual abuse than females with EDs.
- Many men with EDs have experienced separation, loss, or emotional distance from their fathers, which may be an etiological factor of the ED.

Body image, restricting, bingeing, purging, and exercising are the particular symptom areas in which important differences have been observed between males and females (Cumella, 2003). Most women with EDs report the desire to lose weight. Men, however, are split between those who want to gain weight and those who want to lose it. Those who reported wanting to gain weight desired broader shoulders and thicker forearms and legs, and disliked being thin. Males who wish to become larger may gain until their weight is 105 percent of their ideal weight. Compared to women, men reach a much higher body-mass index before they diet.

When referring to food restriction, men who diet usually do so for different reasons than women. Overall, men are more shape-oriented and women are more weight-oriented (Andersen, 2001). Women generally do not need a reason to diet and males tend to diet for specific personal reasons. Andersen (2001) identified four reasons for men dieting: to improve athletic performance; to avoid being teased for having been a fat child; to avoid getting medical diseases associated with males in the family; and to improve a gay relationship.

**Adolescent males with EDs**

Adolescent males comprise approximately 10 to 15 percent of individuals suffering from anorexia nervosa, with the peak onset of the disease for both men and women between the ages of 14 and 18 (Ray, 2004). Only 1 to 3 percent of teenage girls and young women are affected by bulimia nervosa, while the number of adolescent males and young men with bulimia nervosa has been reported to be as low as two-tenths of a percent (Ross & Ivis, 1999).

Spear and Myers (2001) reported that an estimated 85 percent of eating disorders onset during adolescence. Among male patients, Cumella (2003) identified the following three onset groups:

1. **Preadolescent** males may develop an eating disorder in order to reduce teasing from peers related to the preadolescent’s weight.
2. **Adolescent** and young-adult males may develop eating disorders due to sexuality and gender-identity conflicts.
3. **Adult** males may develop eating disorders to gain a sense of masculinity or to control marital and work situations.

Dating back to studies conducted in 1979, bulimia has been associated with substance abuse. In 1997, an Ontario Student Drug Use Survey of 3,990 public and Catholic school students reported that binge eating was significantly related to past-year substance use in both male and female students. Binge eating can also be linked to lower self-esteem, a greater rate of depression, and more problematic and heavier substance misuse. Compared to male students, female students have been reported as more likely to engage in “inappropriate” compensatory behaviors for their binge eating episodes (Ross & Ivis, 1999).

Ray (2004) reported that several adolescent male sub-populations are at higher risk for developing an eating disorder, including individuals who:

- Participate in athletic activities
- Struggle with their sexual identity
- Suffer with co-morbid mental disorders
- Report a family history of eating disorders
- Live in a disordered home environment

Adolescent males involved in athletic activities that require a weight classification or in which a lean body type is preferable are at the highest risk for developing an eating disorder (Ray, 2004). In 2003, researchers performed a study of adolescent males involved in sports that focus on body weight and body image, such as wrestling, swimming, track, rowing, and gymnastics (Patel,
Greydanus, Pratt, & Phillips, 2003). The study showed that these athletes often put excessive pressure on themselves, which would lead them to use maladaptive eating behaviors, including: excessive exercise, caloric and fluid restriction, laxative and diuretic use, self-induced vomiting, and starvation (Patel et al., 2003).

**Conclusion**

Since eating disorders are so often associated with females, men with EDs are often overlooked (Andersen, Cohn, & Holbrook, 2000). Health care professionals do not usually think of eating disorders occurring in men, so important diagnoses are often missed (Andersen, Cohn, & Holbrook, 2000). Therefore, it is essential that social workers become aware that men are at risk for eating disorders, and that they screen clients for EDs when possible. Interacting with each new client, social workers have an opportunity to save lives and stem the increasing cases of males with EDs by improving their ability to diagnose male EDs and by continuing to deepen their understanding of EDs among men and adolescent males.

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**REFERENCES**


**FACTS ABOUT SOCIAL WORK AND HEALTH**

A 2006 study of licensed social workers from the NASW Center for Workforce Studies revealed the following about the practice of health social work:

- There is a potential shortage of social workers in health care services because of the increase in demand for both chronic and acute medical care with the dramatic increase in the number of older adults.

- The Master of Social Work (MSW) is the predominant degree of social workers across health care settings. MSWs comprise 82% of social workers in this practice area.

- More than half of health care social workers are employed in hospitals. Significant numbers of social workers also work in health clinics (14%) and hospices (14%).

- Health care social workers are most likely to practice in metropolitan areas (85%), while few practice in micropolitan areas (7%), small towns (6%), or rural areas (2%).

- Health social workers provide direct services to clients, impart information and make referrals, screen and assess clients, and intervene in crisis situations most often in their area of practice.

- More than three-fifths of social workers report an increase in the severity of client problems, caseload size, paperwork and waiting lists for services.

- Social work in health care settings is a major practice area serving older adults. Health care social workers comprise more than one-third of all social workers who serve predominantly older adult caseloads.

For more information about social workers and health, please visit www.helpstartshere.org/Health_And_Wellness/Default_Page.htm and www.socialworkers.org/pressroom/swMonth/2007/facts2.asp
Homeland Insecurity—American Children at Risk

The teleconference will examine data showing that anti-tax and anti-government policies place children at great risk for low birth weight, infant mortality and premature death. Teleconference discusses why we must make U.S. children a priority and start to focus on children issues including health outcomes, abuse prevention, and other concerns in state-focused campaigns.