URBAN ILLS

TWENTY-FIRST-CENTURY COMPLEXITIES OF URBAN LIVING IN GLOBAL CONTEXTS, VOLUME 2

EDITED BY CAROL CAMP YEAKEY, VETTA L. SANDERS THOMPSON, AND ANJANETTE WELLS

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Volume Two

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This book is dedicated to marginalized communities around the globe, to those engaged in the struggle for equity and social justice, and to those who advocate for them.

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Foreword

Edward F. Lawlor

Not since Jane Jacobs' publication of *The Death and Life of American Cities* has there been such interest, ferment, focus, and analysis of the physical and social dynamics of cities in the United States and globally.

Three forces have combined to elevate the interest and focus on global urban contexts. First, globalization itself, particularly the forces of economic globalization, has created new classes of haves and have nots in cities and across the international landscape. Second, and relatedly, the scale and consequence of natural and man-made shocks have grown, and increasingly spilled over traditional urban or country borders. The best example is climate change, though the global recession effects documented in this book are equally compelling. Third, the speed and accessibility of information flows have created new awareness and cognizance of the plight of urban residents in different contexts and in response to disasters and shocks. When disaster strikes in the Lower Ninth Ward of New Orleans, it is seen globally; when mass incidents occur in China, they are discussed globally. In the flows of social science as well, there is increased awareness of the challenges and research that crosses borders and contexts. Comparative social science has more and more currency in academic, program, and policy settings.

Urban Ills provides a remarkable mosaic of these forces. At the micro level, we learn of the effects of foreclosures, rent control, public housing transformation, environmental degradation, natural disasters, and other influences on households, jobs, and urban life in particular neighborhoods of particular cities. At the meso level, the authors in this collection trace the effects of such broad forces as immigration, human trafficking, the spatial and geographical remapping of cities and suburbs on economic security, health, mental health, and other human outcomes. Finally, the book provides a modern reinterpretation of the human consequences of urban environments and urban change. The "outcome measures" of global urban change in

this volume range from the traditional material measures, to new and expansive measures of health, mental health, marginalization, inequality, and social identity. These chapters do not spare any of the hard issues of race, discrimination, and exploitation that are at the core of so much hardship and disadvantage faced by urban residents.

Perhaps an unintended consequence of assembling this variety of geographies, disciplines, and topics is the stock of innovative ideas about interventions that are either described or triggered by these analyses. Workplace rules, regional planning, utilization of churches, racial practices of schools, are all practical implications that come out of a reading of these chapters. In effect, this collection provides a very provocative modern toolkit—or at least the elements of such a toolkit—for urban, policy, and institutional design.

The temptation in reading *Urban Ills* is to go to one's academic comfort zone. If you are an economist, you are tempted to just read the chapters on economic cause and effect of urban ills; if you are a public health professional, you might read the chapters on HIV or cardiovascular outcomes. To read this collection this selectively, however, would be a big mistake. The huge value of this collection is its breadth, interconnections across contexts and problems, and multiple disciplines. The intellectual ambitions and breadth that the editors have brought to this collection is extraordinary, it would be a shame to miss this larger contribution to understanding urban problems and solutions by picking and choosing chapters.

In *Urban Ills*, we have both extraordinary social diagnoses, but also a stock of ideas and insights for thinking afresh about solutions to the global human challenges of urban residents.

Edward F. Lawlor is Dean and William E. Gordon Distinguished Professor, George Warren Brown School of Social Work, and Founding Director of the Institute for Public Health, Washington University in St. Louis.

Preface

Carol Camp Yeakey, Vetta L. Sanders Thompson, and Anjanette Wells

Utilizing the ecological approach with investigative studies based on original research, *Urban Ills: Twenty-First-Century Complexities of Urban Living in Global Contexts* is divided into two volumes. Volume One focuses on the economic impact on urban life and the social realities of urban living. Volume Two is devoted to urban health and urban communities and their neighborhood dynamics. Reading both volumes brings the discussion and challenges of urban living in the twenty-first century full circle. It is the rich combination of interdisciplinary research in global settings which gives both volumes their credibility and authenticity.

In Volume Two, we delve even more deeply into the ecological fact that "place matters," that the neighborhoods and communities in which one resides have dire consequences and influence on almost every aspect of life and living, throughout one's life course. Some might believe that the greatest strength of cities is found in the downtown areas with their magnificent skyscrapers, art collections, museums, tourist attractions, and expensive high-rise condominium living for the wealthy. However, more conventional wisdom suggests that cities derive much of their strength, vitality and cultural richness from the diverse neighborhoods and communities of which they are made. Those residents who live in distressed neighborhoods, who have little or no stake in their communities, who suffer from urban marginality, struggle feverishly without an opportunity for advancement and social mobility. As a consequence, problems related to poverty, health, housing, crime, joblessness, racism, racial isolation, underachievement, challenges of the "new economy" and hopelessness become all the more intransigent, more difficult to address. As one writer so aptly put it, investing in cities and communities requires more than concern about the self-interest and the rate of return of corporate investors and shareholders (Mainwaring, 2011). Stakeholders, the citizens of the communities, the residents of the neighborhoods, and those who care about the entire city and the environment

must have their concerns addressed as well. Throughout both volumes, the symmetry between national and global concerns has never been more transparent. While globalism reveals the economic interdependence of nation states, we see in our chapters the striking similarity and interconnectedness of many of the social, political and economic dilemmas of our sister nation states, as well.

In tandem, the volumes in *Urban Ills* reflect the extent to which established social science researchers, across the globe, have rejected traditional assumptions and forged new boundaries and the extent to which serious scholars are searching for answers to many of the twenty-first-century complexities of urban living in global contexts. *Urban Ills* is important reading not simply for its answers, but for its beginnings. Together, both volumes represent the beginning of serious dialogue, raise critical questions and challenge basic assumptions which are deserving of public debate and resolve, if we are to evolve into more just and humane societies across the globe.

The Editors

REFERENCE

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Place Matters

Contextualizing Health Using a Social Determinants Model

Will J. Ross

> *A just peace includes not only civil and political rights—it must encompass economic security and opportunity. For true peace is not just freedom from fear, but freedom from want . . . the absence of hope can rot a society from within.*
>
> President Barack Obama, excerpted from his Nobel Prize lecture, December 10, 2009

During a trip to St. Vincent, West Indies, in 1987 as a medical resident at Vanderbilt Medical Center, I was astonished to come across a village where at least a quarter of children ages twelve to eighteen had high blood pressure, defined as greater than the 95 percentile for the child's age, sex and weight. Rather naively, I attributed the findings to a familial clustering of single genes associated with hypertension.

As I began a renal research fellowship at Washington University School of Medicine, I focused my efforts on identifying one putative gene associated with hypertension, the sodium-hydrogen exchanger. Although I was frustrated after a two-year investigation yielded negative results, I should have known better—there are very few monogenetic causes of hypertension. We now appreciate that hypertension is a polygenetic disorder, and that the genes contributing to hypertension are heavily influenced by environmental factors such as stress, diet, working conditions, toxic wastes, and more through a process called epigenetics. Epigenetic mechanisms such as DNA methylation, histone acetylation, and RNA interference, and their effects in gene activation and inactivation, serve to record developmental and environmental cues (Riddihough & Zahn, 2010).

According to David Barker, hypertension and cardiovascular disease may be linked to upstream social factors such as maternal malnutrition contributing to low birth weight due to the developmental plasticity of the human fetus (Barker, 1995). The fetus responds by switching on genes that improves its ability to preserve brain

development while using energy more efficiently; several genes that are turned on in-utero may subsequently predispose the fetus to hypertension, diabetes and cardiovascular disease as a child or an adult. An issue that I did not fully appreciate at the time was that the majority of the children pictured with me in St. Vincent were low birth weight infants.

At the risk of sounding petulant, I sulked for a while, but soon realized it was in the best interest of the children of St. Vincent to instead place more time and emphasis on investigating the upstream social determinants of health as the root cause of their hypertension. Social determinants, e.g., poverty, social exclusion, poor housing, poor health systems, and low educational attainment are the main causes of poor health (World Health Organization Commission on Social Determinants, 2008). They certainly characterize the conditions in which the children lived in St. Vincent, West Indies, and in the United States are the main contributors to the thirty-year gain in life expectancy since 1900. Likewise, they explain the difficulty in providing comprehensive care to a large number of patients trying to wedge through this country's health care safety net. Consider the following case:

> SH is a forty-five-year-old African American female with hypertension, advanced chronic kidney disease, and poly-substance abuse. She uses cocaine and marijuana and has a long history of alcohol abuse. She also smokes half a pack of cigarettes daily. Her history of drug use dates back to when she was a teenager. She has undergone numerous evaluations for chemical dependency without success. She smoked cocaine as recently as last month. She reports increasing weight gain over the past two years and was recently diagnosed with Type II diabetes mellitus. She acknowledges difficulty adhering to a diabetic diet due to an inability in finding affordable fresh produce. She has a history of Hepatitis C but is HIV negative. Her blood pressure has been uncontrolled over the past six months; however, she denies non-adherence with medications. She has been admitted to the hospital for hypertensive emergency four times over the past three months.
>
> She is a divorced mother of five children with a high school education. She was formerly employed as a waitress but is now unemployed and uninsured. She lived with her grandmother after her divorce. She admitted that during times of increased stress she increased her cocaine use and engaged in unprotected sex with multiple partners. Upon questioning she confided a history of early childhood abuse, but she did not desire to offer details. During her visit she is noted to be an anxious but pleasant, overweight female. Her blood pressure was markedly elevated at 240/138, and her heart rate was 120. She had no abnormalities on the physical exam. Her creatinine is elevated at 4.2 mg/dl, and her serum glucose is elevated at 288 mg/dl.

This case, far from being an outlier, is quite typical of those I see in my Renal Specialty Clinic at the Washington University School of Medicine. I was the vice president of Medical Affairs of the last public hospital in St. Louis, St. Louis Regional Medical Center, when it closed in 1997. Afterward, many of the hospital's clients sought care at the Washington University Medical Center. I guess I was the default physician for Regional Hospital referrals, given my long-standing connection with the former institution. A number of these patients lived in North St. Louis, the pre-

dominantly African American part of town. North St. Louis, like many inner city, economically depressed communities, is characterized by low socioeconomic status and high income inequality, high maternal child risk, high sexual risks, increased mortality and reduced life expectancy, and poor health care access indicators. (RHC 2003, *North St. Louis Health Study*, 2008). Public Health interventions with any likelihood of success will have to address the myriad social factors that are manifest in these communities.

HOW DO WE DEFINE SOCIAL DETERMINANTS?

The World Health Organization defines the social determinants of health as: "the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries" (Marmot, 2008). A more pragmatic definition is offered by James (James, 2002, p. 32): "Life-enhancing resources, such as food supply, housing, economic and social relationships, transportation, education and health care, whose distribution across populations effectively determines length and quality of life." Social determinants posit, in essence, that place matters. Those places are distinguished by the distribution of resources to a stable physical, social and built environment.

Well-resourced communities, as demonstrated in figure 16.1 (PolicyLink, 2012), are welcoming communities of opportunities. They have ample, verdant parks and other green spaces, abundant grocery stores with fresh, affordable produce. The streets

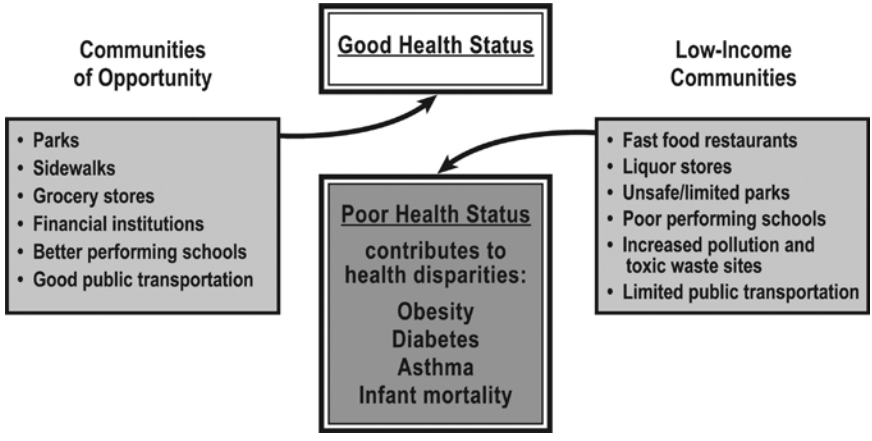

Figure 16.1. Place Matters.
Reprinted with permission. PolicyLink. http://www.policylink.org/site.

have wide sidewalks with jogging and bike paths. High-performing schools with art programs and after-school care provide parents with a wealth of choices for their children, and parents can travel to their well-paying jobs using reliable public transportation if they choose to leave their well-maintained cars at home. Contrast this with low-income communities, where fast food chains and liquor stores dot a landscape of vacant lots, boarded-up buildings, and smaller homes with little if any backyards in which children can play. Schools in such neighborhoods are generally poor performing, and many are unaccredited, with few options for music, art, physical education, or advanced practice courses. Violence and drive-by shootings are a constant threat, and few livable-wage jobs are available. It is no surprise that residents in communities of opportunity are more likely to describe their health status as good, while those in low-income communities are relegated to a life of chronic diseases, overall poor health, and generational poverty (McDonough et al., 1997). Fortunately, there is growing recognition that healthy people and healthy communities go hand in hand.

WHY EMPHASIZE SOCIAL DETERMINANTS?

According to Raphael, social determinants of health have a direct, profound impact on health (Mikkonen & Raphael, 2010). Nowhere is this more clearly illustrated than the seminal Whitehall Studies by Sir Michael Marmot. The initial prospective cohort study, Whitehall I, established in 1967, included eighteen thousand men in the British Civil Service (Marmot et al., 1978). The study found higher mortality rates due to all causes for men of lower employment grade. The study also revealed a higher mortality rate specifically due to coronary heart disease for men in the lower employment grade when compared to men in higher grades. A second longitudinal study of British Civil Servants—Whitehall II (Marmot et al., 1991) was initiated to investigate occupational and other social influences on health and disease. The Whitehall II study documented a similar gradient in morbidity in women as well as men, noting a 3.6 fold difference in mortality between individuals in the lower employment grade and the top grade for those ages forty to sixty-four after a ten-year follow-up. The study revealed a social gradient for a range of different diseases: heart disease, some cancers, chronic lung disease, gastrointestinal disease, depression, suicide, sickness absence, back pain and general feelings of ill health. The Whitehall Study additionally uncovered a social gradient for lifestyle and other risk factors, including smoking, lack of physical activity, obesity, plasma cholesterol, and blood pressure.

Social determinants are known to predict the greatest proportion of health status variance (Mikkonen & Raphael, 2010). As stated above, place matters. Residents in low-income communities experience worse health but also tend to have less access to the social determinants (e.g., healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination that influence health [Brennan et al., 2008]). Health disparities, defined as the variation in rates of disease occurrence and disabilities between socioeconomic and/or geographically de-

fined population groups, persists in marginalized groups (especially racial and ethnic minorities) due largely to their inability to access social determinants. A large body of research underscores the existence and persistence of racial and ethnic health disparities (Smedley et al., 2003). For example, minorities are less likely to be given appropriate cardiac medications or to undergo bypass surgery (Ayanian et al., 1993, Hannan et al., 1999) and are less likely to receive kidney dialysis or transplants (Kasiske et al., 1998). By contrast, they are more likely to receive certain less-desirable procedures, such as lower limb amputations for diabetes and other conditions (Guadagnoli et al., 1995). Shameful and crippling health disparities at the national and global level will persist without coordinated interventions that address social determinants.

Unhealthy health behaviors may stem from social determinants, such as poverty, perhaps the greatest contributor to poor health. Poverty has been linked to higher prevalence of many health conditions, including increased risk of chronic disease, deprived infant development, stress, anxiety, depression, and premature death (Pleis & Lethbridge-Çejku, 2006). The poor are more susceptible to disruptions in their social environment, and as education, childcare, living and working conditions and health care become limiting, they are more likely to lapse into unhealthy behaviors. Sedentary lifestyles, poor diet, non-adherence to medical care and social exclusion may emanate from poverty and the toll of chronic stress (Claussen et al., 2003). A vicious cycle ensues, compromising the ability of the poor to obtain an education, to re-enter the workforce with advanced skills, and to develop self-efficacy and self-management of chronic diseases. All too often in the medical environment poor patients who do not adhere to a prescribed medical regimen are dismissed as "non-compliant." What a judgmental, loaded term, which blinds the health provider to the myriad social factors that preclude effective medical partnerships!

CAN WE AS A COUNTRY AFFORD TO ADDRESS SOCIAL DETERMINANTS OF HEALTH? COUNTERING THE FINANCIAL, MARKET-BASED ARGUMENT WITH AN EGALITARIAN, MORAL-BASED ONE

A human rights–based approach to addressing social determinants was offered, perhaps tacitly, by the World Health Organization when its definition of health was codified in the constitution and adopted by the International Health Conference in 1946 (WHO, 1946). The preamble clearly articulated that "governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures." That issue, the appropriate role of government in improving the health of the population, has befuddled policymakers and health professionals for decades. The costs of providing "adequate health and social measures" can be staggering, since the definition of "adequate" can be so subjective. Do adequate social measures encompass increased policing to reduce youth violence, greater surveillance of nutrition menus in schools to reduce childhood obesity,

development of housing free of environmental toxins, and provision of working-class wages to reduce poverty?

There is little concordance that these measures are within the domain of health, so why should the government increase health expenditures, already at 18 percent of our gross domestic product (OECD, 2011), on social measures that may be perceived as beyond the purview of health? And if, in a newly enlightened state, there was a commitment to improve health through addressing social determinants, what conceptual framework offers the best course of action? Sir Michael Marmot (WHO, 2008), former Chair of the Commission of Social Determinants of Health, offered three principals of action as a first step:

1. Improve the conditions of daily life—the circumstances in which people are born, grow, live, work, and age.
2. Tackle the inequitable distribution of power, money, and resources—the structural drivers of those conditions of daily life—globally, nationally, and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

There will, of course, be those who criticize the social determinants model as a socialist agenda; they should be reminded that embarking on such a course has historic and contemporary precedents. First is the reconstruction of Europe post World War II, an American-led effort known as the Marshall Plan (Hogan, 1987). Named after Secretary of State George Marshall and formally known as the European Recovery Program, the Marshall Plan aimed to stabilize European economies plagued by severe food shortages, unemployment, and depressed industrial production. Secretary Marshall delivered a major speech at the Harvard University Commencement in June 1947 to galvanize support for the plan (OECD, 1947, p. 52) and concluded, "It is logical that the United States should do whatever it is able to do to assist in the return of normal economic health in the world, without which there can be no political stability and no assured peace." He furthermore stated that: "Our policy is not directed against any country, but against hunger, poverty, desperation and chaos." After extensive negotiations Congress finally allocated $12.4 billion to implement the Marshall Plan (Guinnane, 2004). I daresay that anyone would question the legacy of that bold initiative or the remarkable return on investment for American and other benefactors.

The Millennium Development Goals, a framework for global development adopted by 189 heads of state in September 2000 (UN General Assembly, 2000), were similarly established to address the human rights of all global citizens to health, education, shelter, and security. The eight Millennium Goals are:

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education

3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

Achieving and sustaining these goals would not be possible without proper attention to the broader social factors that influence health. The world has made significant progress in achieving many of the goals. For the first time since the World Bank started to monitor poverty trends, both the number of people living in extreme poverty and the poverty rates fell in every developing region—including in sub-Saharan Africa, where rates are highest. Between 1990 and 2002 average overall incomes increased by approximately 21 percent. The number of people in extreme poverty declined by an estimated 130 million. Child mortality rates fell from 103 deaths per 1,000 live births a year to 88. Life expectancy rose from sixty-three years to nearly sixty-five years. An additional 8 percent of the developing world's people received access to water. And an additional 15 percent acquired access to improved sanitation service (UN Millennium Assembly, 2000).

From February 2008 to December 2009, the Robert Wood Johnson Foundation (2009) charged the newly formed Commission to Build a Healthier America to investigate the broader factors that influence health. The Commission compiled some of the most compelling data to date, documenting the powerful effects of such factors as educational attainment on infant mortality (figure 16.2) (Mathews & McDorman, 2007) and overall health (figure 16.3) (Centers for Disease Control and Prevention, 2008).

The Commission subsequently issued ten recommendations to improve health at the local, state and federal level:

1. Fund and design WIC and SNAP (food stamps) programs to meet the needs of hungry families for nutritious food.
2. Create public-private partnerships to open and sustain full-service grocery stores in communities without access to healthful foods.
3. Feed children only healthy foods in schools.
4. Require all schools (K–12) to include time for all children to be physically active every day.
5. Become a smoke-free nation. Eliminating smoking remains one of the most important contributions to longer, healthier lives.
6. Ensure that all children have high-quality early developmental support (child care, education and other services). This will require committing substantial additional resources to meet the early developmental needs particularly of children in low-income families.
7. Create "healthy community" demonstrations to evaluate the effects of a full complement of health-promoting policies and programs.

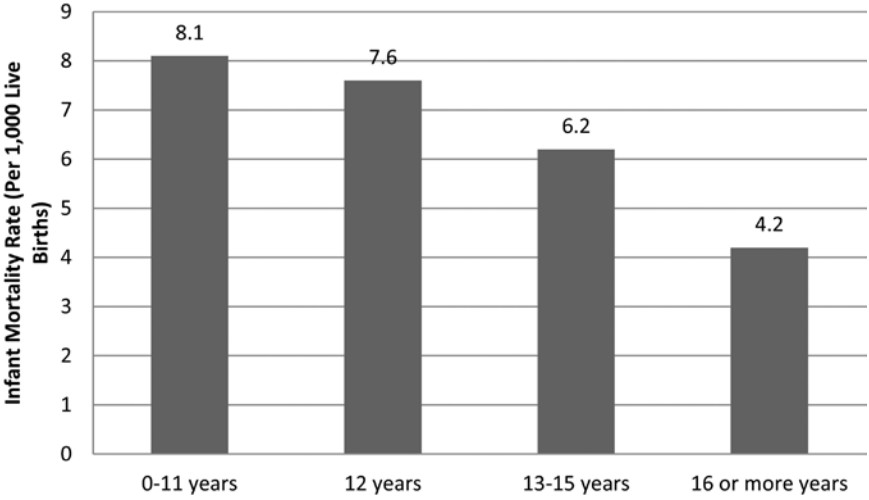

Figure 16.2. A Mom's Education, A Baby's Chances of Survival.
Babies born to mothers who did not finish high school are nearly twice as likely to die before their first birthday as babies born to college graduates.

Source: Mathews, T.J., MacDorman, M.F. Infant mortality statistics from the 2004 period linked birth/infant death dataset. National Vital Statistics Reports*, 55 (14). Hyattsville, MD: National Center for Health Statistics, 2007. Reprinted with permission. Courtesy of the Robert Wood Johnson Foundation Commission to Build a Healthier America.*

8. Develop a "health impact" rating for housing and infrastructure projects that reflects the projected effects on community health and provides incentives for projects that earn the rating.
9. Integrate safety and wellness into every aspect of community life.
10. Ensure that decision makers in all sectors have the evidence they need to build health into public and private policies and practices.

Since Surgeon General Julius Richmond first established a national prevention agenda in 1979 (Richmond, 1979), our nation has relied on Healthy People to provide concrete objectives to guide public health activities. The most recent national preventive health framework, Healthy People 2020 (Healthy People, 2010), is historic in that it highlights the importance of addressing the social determinants of health by including "create social and physical environments that promote good health for all" as one of the four overarching goals for the decade (figure 16.4).

Following the 2008 WHO Commission on Social Determinants and the Robert Wood Johnson Foundation Commission to Build a Healthier America, Healthy People 2020 has spurred considerable local, state and federal action around preventive health and has re-invigorated the nation's research agenda to create an evidence base of effective approaches that address social determinants. These frameworks in-

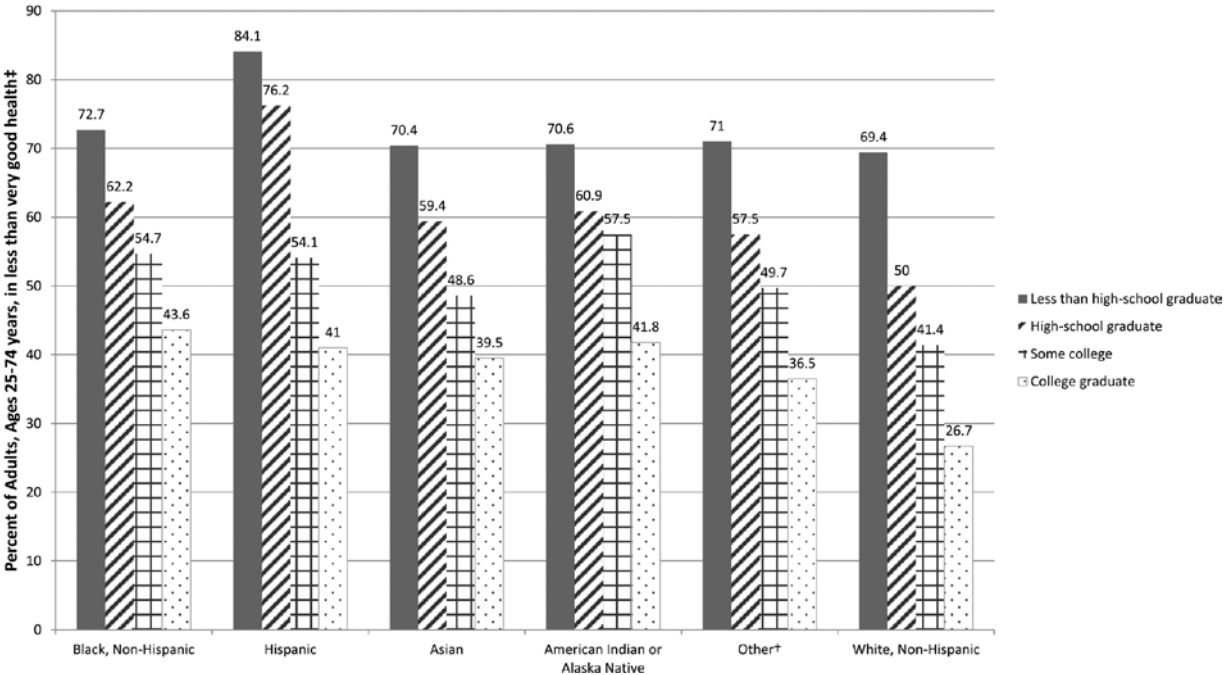

Figure 16.3. Education Is Linked with Health Regardless of Racial or Ethnic Group.
2005–2007 Behavioral Risk Factor Surveillance System Survey Data.

1. Based on self-report and measured as poor, fair, good, very good or excellent.

2. The national benchmark for adult health status represents the level of health that should be attainable for all adults in every state. The benchmark used here—19.0 percent of adults in less than very good health, seen in Vermont—is the lowest statistically reliable rate observed in any state among college graduates who were non-smokers with recent leisure-time physical exercise. Rates with relative standard errors of 30 percent or less were considered to be statistically reliable.

† Defined as any other or more than one racial or ethnic group, including any group with fewer than 3 percent of surveyed adults nationally in 2005–2007.

‡ Age adjusted.

Adult health status improves as educational attainment increases, with a steep education gradient evident within each racial or ethnic group. Among Hispanics, for example, adults who have not graduated from high school; those who have only completed high school; and those who have some college education are 2.0, 1.9, and 1.3 times as likely to be in less than very good health as college graduates.

Reprinted with permission, courtesy of the Robert Wood Johnson Foundation Commission to Build a Healthier America.

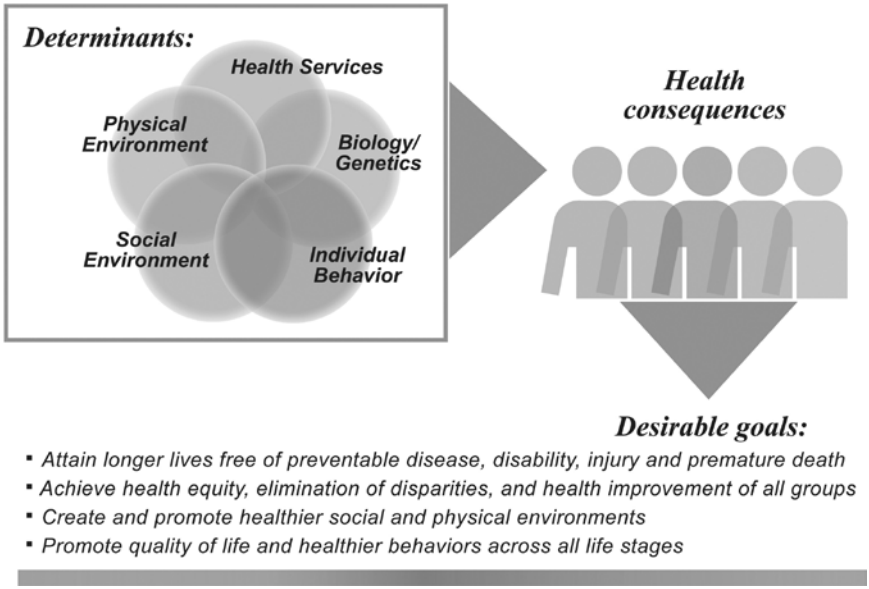

Figure 16.4. Healthy People 2020: A Society in which All People Live Long, Healthy Lives.

Healthypeople.gov/2020. Reprinted with permission.

terface seamlessly with other U.S. health initiatives such as the *National Partnership for Action: HHS Action Plan to Reduce Racial and Ethnic Health Disparities* (*National Partnership for Action*, 2011), *The National Stakeholder Strategy for Achieving Health Equity* (*National Stakeholder*, 2011), and the *National Prevention and Health Promotion Strategy* (*National Prevention*, 2011).

State and local communities have an additional tool to conduct health assessments using the University of Wisconsin County Health Rankings Model (University of Wisconsin Population Health Institute, 2012), which has been funded through the Robert Wood Johnson Foundation. Recognizing that genetic factors contribute to at most 25 percent of our overall health (Rappaport, 2010), the County Health Rankings stratifies the remaining factors into four components: heath behaviors, which includes tobacco use, alcohol use, diet and exercise, and unsafe sex; clinical care, which includes access to care and quality care; social and environmental factors, covering education, employment, income, family and social support and community safety; and physical environment, which includes the built environment and environmental quality. The County Health Rankings show that people who live in healthier counties tend to have higher education levels, are more likely to be employed, have access to more health care providers, and have more access to healthier foods, parks and recreational facilities.

AT THE NEXUS OF THEORY AND PRACTICE: PRACTICAL APPROACHES TO IMPROVING HEALTH OUTCOMES BY ADDRESSING SOCIAL DETERMINANTS

More than just conceptual frameworks, Healthy People 2020 and the other aforementioned initiatives offer practical examples of how to operationalize a social determinants framework, with the body of robust research in the area growing rapidly. I have had the opportunity to witness firsthand some remarkable public health programs in the country that utilize social determinants models, from reducing infant mortality in Dane County, Wisconsin, combating youth violence in East Los Angeles, and recovering from Hurricane Katrina in the Lower Ninth Ward in New Orleans. These examples have been covered widely in the media and social science and public health journals. There are a few additional practical approaches that warrant highlighting:

Jackson, Mississippi, Medical Mall: A Comprehensive Multidisciplinary Health Care Complex

After experiencing a boom in its population in the 1980 census (U.S. Department of Commerce, 1983), Jackson, Mississippi, experienced an inexorable decline in its population as its surrounding suburbs grew in population and wealth. An abandoned shopping mall in the city, replete with the characteristic broken windows, served as a reminder to those residents who could not afford to relocate that their community was suffering. In 1995 Dr. James Shirley, an African American physician, and several other community leaders decided to transform the abandoned mall into a full service community center (Jackson Mall, 2012). They established as their goals:

1. to promote greater access to cost-effective, high-quality health care for central Mississippi;
2. to facilitate integration of human service delivery with health care delivery;
3. to stimulate economic and community development in the area surrounding the mall (the median family income of the midtown area was less than $17,000, its poverty rate was at 41 percent, and over 16 percent of residents were unemployed);
4. to utilize health care delivery activities to enhance educational opportunities;
5. to build the financial strength of the foundation to ensure future reinvestment in the community.

Health care and social services re-located in the Medical Mall include: Hinds County Health Department Clinic; University of Mississippi Medical Center specialty clinics, including clinics for cardiology, obstetrics and gynecology, and oncology; Mississippi Health Advocacy Program, the site for health education classes by

UMC Pharmacy and Nursing School; Jackson State School of Public Health; and the Jackson Heart Study. The facility also includes a community meeting room, center stage, and mall common area where many community events, ranging from general meetings, concerts and plays occur. In 1997 the NIH joined with the medical mall to establish a center where area residents could gain easy access to NIH health information (Jackson-NIH, 2010).

The center includes materials on such topics as vision health, cancer, heart disease, dental care, diabetes and sudden infant death syndrome. It provides a vehicle to disseminate accurate, up-to-date health information to the more than 165,000 people, mostly patients, who come to the Jackson Medical Mall every year. Recently, Jackson residents joined with NIH staff to conduct a series of four community health forums and continuing medical education forums. The Jackson/NIH team identified health literacy, diabetes and mental health, along with heart disease and stroke, as health issues important to the residents of Mississippi.

Homeboy Industries: New Approaches to Reducing Youth Violence

East Los Angeles is home to some of the most notorious gangs in the country, known for a number of criminal activities that range from murder, arms trafficking, drug sales to drive-by shootings and assaults (Violent Crime Mapping, 2010). It is also one of the most neglected communities in California (Tita, 2003). Ameliorating gang violence would require a multilevel strategy, employing ecological models to address the multiple social factors underlying violence (figure 16.5). Such approaches are being used with increasing effectiveness by national programs such as Gang Resistance Education and Training (GREAT, 2012).

In 1988, then-pastor Greg Boyle, SJ, began a job-training program called Homeboy Industries to offer an alternative to gang life for high-risk youth who were living in East LA, the area with the highest concentration of gang activity (Freeman, 2008). Homeboy Industries continues to serve at-risk and gang-involved youth with a continuum of social services and programs designed to meet their multiple needs, and it runs four businesses that serve as job-training sites. The organization offers a variety of free programs, such as mental health counseling, legal services, tattoo removal, curriculum and education classes, work-readiness training, and employment services. After watching hardened ex-cons cry as they describe the impact of Homeboy Industries on their lives, I had to agree with their slogan: "Nothing Stops a Bullet Like a Job."

Health Literacy: An Often Overlooked but Powerful Determinant of Health

Health literacy is defined in the Institute of Medicine report *Health Literacy: A Prescription to End Confusion* (Institute of Medicine, 2004) as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." There are many

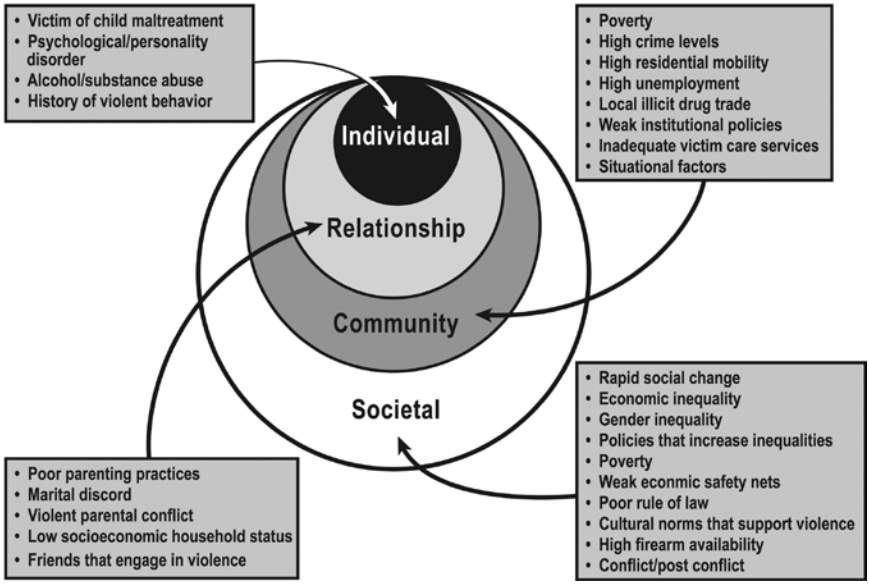

Figure 16.5. Ecological Model Showing Shared Risk Factors for Sub-Types of Interpersonal Violence.

Butchart A, Phinney A, Check P, Villaveces A. Preventing Violence: A Guide to Implementing the Recommendations of the World Report on Violence and Health. *Department of Injuries and Violence Prevention, World Health Organization, Geneva, 2004. Reprinted with permission.*

competing definitions for health literacy, but defined this way, health literacy goes beyond a narrow concept of health education and individual behavior-oriented communication and addresses the environmental, political and social factors that determine health. Measuring the impact of individual or population-based interventions to improve health literacy has been difficult because, as a social construct, it is developed in response to our expanded cognitive skills as well as the product of social interactions (DeVellis, 1991). Health literacy thus functions as a latent construct—not directly measured, but estimated through proxy measures such as family structure, educational attainment, economic status, health care access, and other contextual factors (Ross, 2009). It is at the core of social determinants of health, but as a latent construct it is often overlooked when intervention strategies are being developed.

In an attempt to demonstrate the impact of health literacy on ameliorating health disparities, Chandra Osborn and colleagues (Osborn, 2007) studied the effect of low health literacy on the relationship between race and HIV-medication adherence in a cohort of 204 individuals infected with HIV. After adjusting for relevant covariates and excluding health literacy, African Americans were 2.40 times more likely to be nonadherent to their HIV medications than whites (95 percent confidence interval 1.14 to 5.08). However, when health literacy was added to the model, the effect

estimates of African American race diminished to nonsignificance (aOR 1.80, 95 percent confidence interval 0.51 to 5.85).

The authors concluded that improved health literacy mediated medication adherence, however the study recognized that other factors were contributing to racial disparities. This was the first study to assess the impact of limited health literacy in explaining racial/ethnic differences in medication adherence among a sample of patients from both urban and rural settings. Strategies considered most effective in enhancing health literacy should adhere to an ecological framework, wherein program activities address the broader social determinants of health. The implications of this study are more far reaching, in that health literacy, unlike race/ethnicity, is potentially modifiable.

CARE THAT ADDRESSES THE SOCIAL CONTEXT

Effective health care delivery must take the socioeconomic context of the individual seriously—recognizing the complex interplay between individual and community resources. The delivery of health services, in taking into account the characteristics and needs of vulnerable communities, must address the many resource limitations these communities will face. This will involve assessing the communities' strengths and weaknesses, identifying the supports and barriers in the environment, and identifying the non-medical resources that may be mobilized to assist the community. Moreover, contextual care can be assured if policymakers, including those in non-health sectors, adopt an approach where health consequences are considered in all policies and programs. This approach, Health-in-All-Policies, is defined as a combination of procedures, methods, and tools by which a policy, program, or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population (Collins et al., 2009; European Centre for Health Policy, 1999). Such Health Impact Assessments (HIA) identify actions to manage those effects (Gothenburg, 1999).

The U.S. Department of Health and Human Services now recommends HIA as a planning resource for implementing Healthy People 2020 (*National Prevention and Health Promotion Strategy*, 2011).

HIA policy areas include:

1. Housing Policies
2. Employment Policies
3. Community Development Policies
4. Income Support Policies
5. Transportation Policies
6. Environmental Policies
7. Agricultural Policies

HIA holds promise for incorporating aspects of health into decision making because of its

1. Applicability to a broad array of policies, programs, plans, and projects;
2. Consideration of adverse and beneficial health effects;
3. Ability to consider and incorporate various types of evidence; and
4. Engagement of communities and stakeholders in a deliberative process.

MOVING FORWARD: CONCEPTUAL FRAMEWORK AND STRATEGIES TO IMPROVE COMMUNITY HEALTH USING THE SOCIAL DETERMINANTS MODEL

If we were to pull off the Sisyphean feat of developing a global Marshall Plan to effectively address social determinants of health in all policies, we might find that the

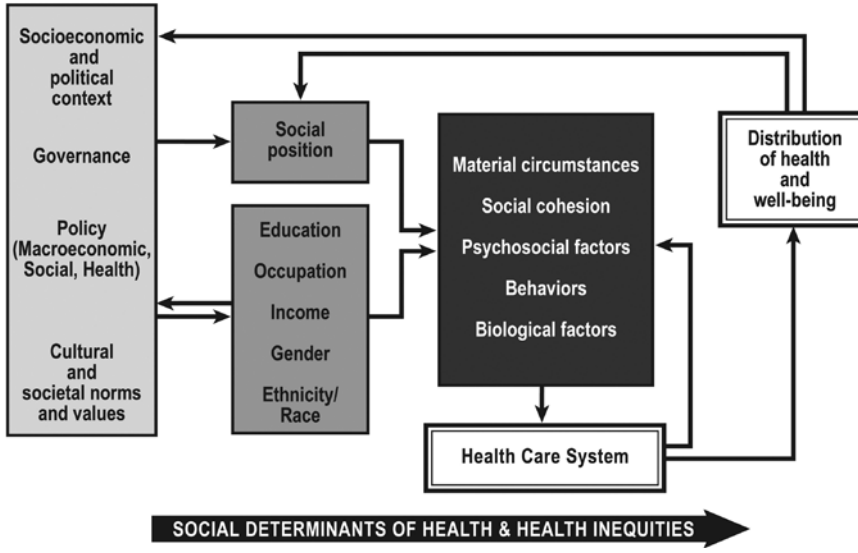

Figure 16.6. Social Determinants of Health and Health Inequities.
The conceptual framework demonstrates how social, economic, and political mechanisms result in the stratification of populations by socioeconomic status, power and prestige, for which race/ethnicity, gender, social class, education, occupation, and income are often proxy indicators. The model assumes that those with lower socioeconomic position have less favorable material circumstances, health behaviors, psychosocial factors, and experiences with the health system. The framework provides a point from which researchers can take action, such as creating targeted interventions, on social determinants of health.
Adapted with permission, CDC. Commission on Social Determinants of Health. Reproduced by Solar and Irwin. April 2007. Elaborated by EQH/EIP 2006 (OPSH). Reprinted with permission.

limiting factor is not necessarily the financial costs, which would be jaw dropping. We may be limited more by the paucity of the public health workforce that could be called in to help implement the plan. The United States has an estimated fifty thousand fewer public health workers than it did twenty years ago (ASPH, 2008). Governmental public health departments are facing significant workforce shortages that will likely be exacerbated through retirements and the current economic downturn, and by years end, over 50 percent of some state health agency workforces will be eligible to retire (ASTO, 2008). Additionally, according to the AAMC's Center for Workforce Studies, a shortage of more than forty-five thousand primary care physicians is predicted to occur within the next ten years (AAMC, 2010). Consequently, there is an increasing need, if not a moral imperative, for schools of public health and health professions to produce a cadre of trainees who will be well tutored in the social determinants of health and the cross-departmental, interdisciplinary approaches needed to operationalize a social determinants model.

At Washington University, the recently created Institute for Public Health outlined several key initiatives: Health Disparities in the St. Louis Region; Environment and Health; Genetics and Population Health; International Diseases and Interventions; and Health Services and Policy, that would move its core activities closer to addressing social determinants of health. Likewise, at the Washington University School of Medicine, the Office of Diversity Programs has expanded its mission to encompass community and population health. Those efforts were informed by the 2011 AAMC Graduate Questionnaire (AAMC, 2011), in which 47.5 percent of Washington University School of Medicine graduates felt that inadequate time was devoted to instruction on the role of community health and social service agencies. The past decade has witnessed the genesis of an encouraging, if not belated, integration of curriculum between schools of medicine and public health. Both schools appropriately affirm that improving public health education within the academic workforce is not only a moral imperative but also a hallmark in the national effort to eliminate health inequities. Increasingly, academic medical centers, prodded by their public health school colleagues, are recognizing that medical education should encompass a broader understanding of the sociocultural factors that influence health.

Consequently, improving the health of our communities and resolving health inequities will require academic medical centers to similarly re-evaluate their missions and re-align their curriculum and clinical practice agendas to achieve measurable outcomes in producing that a workforce understands the social determinants of health. The Washington University Medical Center has designed an array of programmatic activities that have been developed to heighten medical students' awareness and understanding of community-based health and social determinants of medicine. These programs aim to increase students' knowledge, skills, and attitudes about community-based health and health inequities. They have endeavored to reconcile changes in medical student knowledge, skills and attitudes with public health competencies promulgated by the Association of Schools of Public Health (ASPH,

2012). The intent is to add to evidence-based approaches using service learning to allow students to fully understand the social determinants of health, and hopefully impress upon them that they can impact health inequities in the early, formative years of their medical education.

CONCLUSION

Social determinants of health are mostly responsible for the health inequities that ravage our society. As a society we must be guided by stronger moral forces as we begin to develop comprehensive strategies to ameliorate health inequities. Paramount in this effort is the development of social determinants models that encourages collaborative community health planning and draws on well-tested conceptual frameworks and evidence-based strategies. Successful strategies, as have been illustrated, incorporate health impact assessments that demonstrate the interconnectedness of national and global macro policies. Health planning and health impact assessments should be based on an understanding that a patient's entire life course affects the manifestation and perception of disease. As a matter of course, systemic health reform providing improved access to care, as outlined in the Patient Protection and Affordable Care Act (PPACA, 2010), should be considered necessary but not sufficient to uplift unhealthy communities. Healing communities can be developed and sustained in a holistic manner, with attention to an individual's entire life course and the broader social forces that influence health. This will occur when health care, delivered in neighborhoods, is tied to the formation of a safe living environment, living wage jobs, affordable housing, and high-quality schools.

Globally, the move to incorporate social determinants of health and the adoption and diffusion of health impact assessments have outpaced initiatives in the United States. Recently, members of the World Council on Social Determinants of Health in Rio de Janeiro (WHO, 2011) were unwavering in their embrace of concerted effort in that area:

> We, Heads of Government, Ministers and government representatives, solemnly reaffirm our resolve to take action on social determinants of health to create vibrant, inclusive, equitable, economically productive and healthy societies, and to overcome national, regional and global challenges to sustainable development. We offer our solid support for these common objectives and our determination to achieve them. (p. 15)

Nonetheless, we in the United States should be undeterred: we must accept that we are all inextricably linked in this growing movement that recognizes that healthy people and healthy places go together. Local and state health departments, academic medical centers and social service non-profit organizations, and civic and community leaders and other stakeholders can enter into a durable collaboration that strives, one community at a time, to create healthy places and healthy people.

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17

Social Dis(ease) of African American Males and Health

Keon L. Gilbert, Rashawn Ray, and Marvin Langston

Compared to other U.S. populations, African Americans face some of the worst health outcomes, resulting in an average life expectancy five years less than Whites' (National Center for Health Statistics, 2009; Kung, Hoyert, Xu, & Murphy, 2008; Smedley, Stith and Nelson, 2003). As overall mortality and morbidity has improved in the United States, black men remain more likely to die from chronic diseases such as cardiovascular disease, diabetes, and cancers compared to their White counterparts. The stark reality of African American male health is complex and has deep historical ties to the legacy of slavery. The social marginalization of African American men from slavery has stifled their health, social, economic and political mobility. There has been a modicum of individual success, such as the rise of Barack Obama into the presidency, however, for the majority of African American men, irrespective of social class, their health progress is bleak. This chapter seeks to characterize the unique characteristics of African American men, their health, the role of masculinity and male role norms, and finally community-based recommendations on how to engage African American men into public health interventions.

HEALTH PROFILE OF AFRICAN AMERICAN MEN

There is something unique about the health profile of African American men. The following epidemiological profile should not be read within a vacuum—meaning that these stark realities are the result of several intersecting factors that superficially reveal a more complex story of racialized and gendered experiences for African American men. African American men are 30 percent more likely to die from heart disease and 60 percent more likely to die from stroke than non-Hispanic White men (Office of Minority Health, 2012).

Table 17.1. Leading Five Causes of Death for Males, by Race/Ethnicity

Rank++	*Black or African American*	*All Races*	*White*	*Hispanic or Latino*	*Asian or Pacific Islander*
1	Cancer	Cancer	Cancer	Cancer	Cancer
Deaths^	97,673	878,185	712,911	43,632	18,724
Mortality Rate*	285.8	217	220.5	141.4	128.8
Percent**	22.3%	24.2%	24.9%	19.2	26.6%
2	Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart Disease
	91,365	872,017	715,782	42910	15,915
	273.7	223.5	227.9	152.2	119.4
	20.8%	24.0%	25.0%	18.9%	22.6%
3	Cerebrovascular Disease	Cerebrovascular Disease	Cerebrovascular Disease	Cerebrovascular Disease	Cerebrovascular Disease
	21,954	162,160	124,449	9,958	4,789
	66.7	42.4	40.4	34.4	36.3
	5.0%	4.5%	4.3%	4.4%	6.8%
4	Homicide	Homicide	Homicide	Homicide	Homicide
	21,814	42,778	10,897	8,601	753
	37.3	9.4	3.7	10.9	3.5
	5.0%	1.2%	0.4%	3.8%	1.1%
5	Hypertension	Hypertension	Hypertension	Hypertension	Hypertension
	18,289	76,142	50,486	4,872	1,849
	51.2	18.9	15.9	15.8	14.0
	4.2%	2.1%	1.8%	2.1%	2.6%

^Number of deaths; *Age-adjusted mortality rates per 100,000 standardized to the U.S. year 2000 population
**Percent of total deaths within race/ethnicity group; ++Ranking based on numbers of deaths for Blacks/African Americans
Citation: Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2008. CDC WONDER Online Database, compiled from Compressed Mortality File 1999–2008 Series 20 No. 2N, 2011. Accessed at http://wonder.cdc.gov/cmf-icd10.html on June 27, 2012, 6:26:00 PM.

The top five leading causes of death for African American men are cancer, heart disease, cerebrovascular disease (stroke), homicide and hypertension (Table 17.1). In all categories, the mortality rate exceeds that of the total population, White, Hispanic/Latino and Asian/Pacific Islander men.

In one study, although African American men with a college degree reported the lowest levels of cigarette smoking, physical inactivity and overweight status, they had higher levels of hypertension than high school graduates (Diez-Roux et al., 1999). AIDS is seven times more prevalent in African American men than White men, and African American men are more than nine times more likely to die from AIDS and HIV-related diseases. African American men are two times as likely to need treatment for severe kidney disease as a co-morbidity from diabetes (Graham & Gracia, 2012). Deaths from cancers such as lung and prostate comprise the majority of cancer-related deaths for African American men.

A major driving force for many of these chronic diseases is the rising rate of obesity for African American men. Figure 17.1 shows the steady rise of obesity for adult African American men, which over the past five years has constantly remained above the rate for all men. Of African American men aged forty to fifty-nine years, 40 percent are obese and 38 percent of African American men sixty and above are obese (Flegal et al., 2010; Kumanyika et al., 2008). Men with a body mass index (BMI) equal or greater than forty are 50 percent higher in African American men compared to White men, and the rate is doubled for men aged sixty and above. An estimated 50 percent of African American men report no leisure-time physical activity (Ward et al., 2004). African

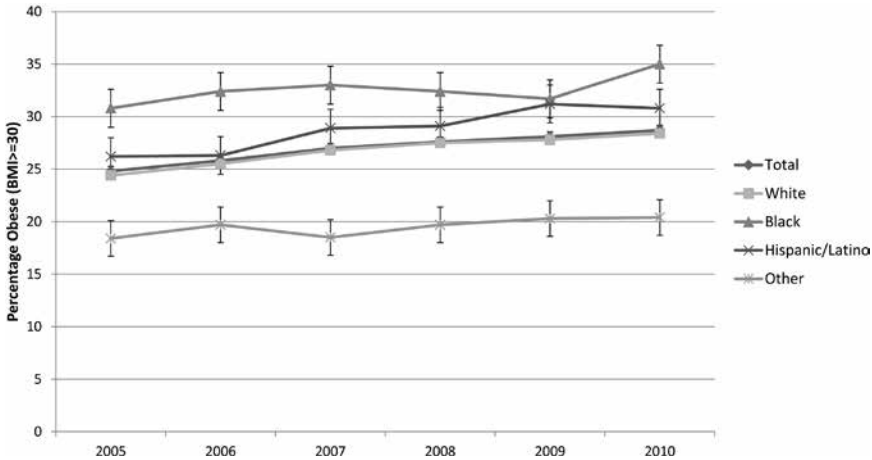

Figure 17.1. U.S. Male Obesity 2005–2010.

Error Bars Indicate 95% CI for the percentage.

Data Based on the Behavioral Risk Factor Surveillance System Survey (BRFSS) 2005–2010.

Citation: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2005–2010.

American men are reported to only consume on average 3.5 of the nine recommended fruit and vegetable daily servings (National Cancer Institute, 2002).

In 2004, African American men were among the highest group in the world to utilize health care services (Leigh, 2004), largely due to men being less likely to have access to quality health care and less likely to seek preventive health care services. African American men are 75 percent less likely to have health insurance compared to White men (Office of Minority Health, 2010). 30 percent of men compared to 19 percent of all women do not have a regular physician (Sandman, Simantov, & An, 2000). African American men in all income groups are 50 percent less likely to have had contact with physicians in the past year (US Department of Health and Human Services, 1998). There is no concerted effort to ensure that men in general have health care coverage (Bonhomme & Young, 2009; Treadwell & Ro, 2003).

CULTURAL AND STRUCTURAL FACTORS: INTERSECTIONS OF RACE, GENDER AND HEALTH

What health researchers in several disciplines such as African American studies, sociology, psychology, public health, and anthropology are concerned with is how to explain disease causation using past and present experiences that have lead to inequalities in health (Krieger, 1994). Part of understanding the causes of disease requires a new paradigm that seeks to understand the connection between the biological, psychological and social factors that contribute to disease. These factors are shaped by a particular history within the context of the everyday life of the human population. Examining everyday experiences, the impact of racism at work, for example, is evidenced in acute conditions such as headaches, chest pains, hyperventilation and hair problems (Feagin & McKinney, 2003). These acute health conditions can over time translate into higher risks for chronic diseases such as cardiovascular disease. Poor health behaviors that lead to poor health status can be understood through the social and psychological factors that can lead to these behaviors and how these behaviors constitute changes in biological functions over time, thereby placing people of color at greater risk for chronic diseases. Additionally, there is a body of research positing that exposure to racial bias adversely affects physiological and psychological functions in laboratory studies (Anderson, Myers, Pickering, & Jackson, 1989; Armstead, Lawler, Gordon, Cross, & Gibbons, 1989; Jones, Harrell, Morris-Prather, Thomas, & Omowale, 1996; Morris-Prather, Harrell, Collins, Leonard, Boss, & Lee, 1996; Lewis et al., 2009; Neblett & Carter, 2012).

Impoverished communities are formed as a result of racial and ethnic minorities' subjectivity to many forms of institutional and structural forms of racism that have contributed to generations of poverty (Sewell, 2010; Charles, 2003; Oliver and Shapiro, 1995). Formal and informal policies have reified the status of minorities and prevented significant economic development. For example, early Southern Jim Crow laws gave rise to convict leasing systems. This system authorizes police

to arrest young African American men for petty crimes who would receive lengthy prison sentences. These young African American men were then leased by prisons to former slave owners, thus becoming free laborers without rights or expectations of health care, good nutrition, education and decent housing. Other examples include historical accounts of Black businesses being burned to the ground and Black business owners being lynched. Black poverty has become endemic to American culture, and without a social justice framework to redistribute wealth by providing greater economic and educational opportunities for Blacks, forms of poverty will persist (Conley, 2009; Fairclough, 2002; Franklin & Moss, 200; Kelley, 2000).

(UN) EMPLOYMENT AMONG BLACK MEN

As a result of systematic disinvestment in many Black communities, African American men and women have experienced high rates of unemployment. If we look at employment rates from 2006 to 2010, African American men fall below the national average, as well as those of White, Asian, and Hispanic/Latino men presented in table 17.2.

There has been a steady decline in employment for African American men. These data are further punctuated by examining chronic unemployment (figure 17.2) of Black men, which has nearly doubled between 2006 and 2010, from 9.5 percent to 18.4 percent. During this same period, unemployment for White and Asian men has more than doubled from much lower initial rates of 4 and 3 percent, respectively. Unemployment for Hispanic/Latino men has tripled, to 12.7 percent, but it still remains lower than Black male unemployment. During this current economic recession, Black male unemployment rates have steadily remained above the national average, as well as those of all other racial and ethnic groups presented in table 17.2.

Chronic unemployment challenges the very notion of traditional male role norms as "laborer" or "provider" and places Black manhood in a more precarious position. Men not being able to adhere to these traditional male role norms threatens their role as family supporters, resulting in a less than full partnership with their spouses in

Table 17.2. Male Employment Ratios by Race/Ethnicity, 2006–2010 Annual Averages

	2006	*2007*	*2008*	*2009*	*2010*
Black	60.6	60.7	59.1	53.7	53.1
White	71.3	70.9	69.7	66.0	65.1
Asian	72.7	72.8	72.2	68.7	67.5
Hispanic or Latino	76.8	76.2	74.1	68.9	68.0
Total	70.1	69.8	68.5	64.5	63.7

Source: Labor Force Characteristics by Race and Ethnicity, 2010
Report by U.S. Department of Labor and U.S. Bureau of Labor Statistics (Released August 2011), Report #1032. These annual averages are based on the U.S. population.

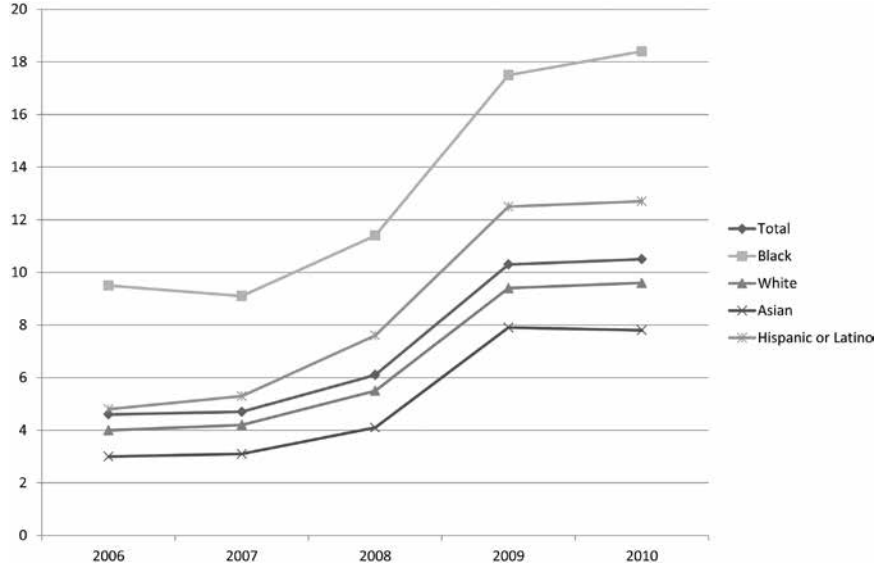

Figure 17.2. Male Unemployment Ratios by Race/Ethnicity, 2006–2010.

Source: Labor Force Characteristics by Race and Ethnicity, 2010 Report by U.S. Department of Labor and U.S. Bureau of Labor Statistics (Released August 2011), Report #1032. These annual averages are based on the U.S. population.

their ability to serve as the "male family head" who takes care of his family economically, emotionally and morally.

Institutional racism has eroded the traditional sensibilities of manhood for many African American men. What it means to be male is influenced by historical, social, cultural, and economic factors. Male identity is signified by beliefs and behaviors that are practiced in social interactions and, therefore, varies between cultures and individuals (Moynihan, 1998). The dominant form of masculinity in western societies is one imbued with hegemony that privileges traditional gender norms and family forms (Ray, 2008; Ray & Rosow, 2010). The major factors associated with ideal masculinity include avoidance of feminine behaviors, display of dominance and power, portrayal of independence and stoicism, and embracing risk behaviors (Brannon, 1976; Courtenay, 2000; Hong, 2000), and for many African American men to embrace the provider role for their families (Ray 2008; Bowman, 1989). African American men in their middle-adult years often evaluate their sense of manhood against their ability to fulfill their roles as provider, husband, father, employee and community member (Ray, 2008; Hammond & Mattis, 2005; Bowman, 1989; Cazenave, 1979). Many African American men cannot assume these roles as a result of a cycle of poverty emerging from a history of African American men being paid less than 75 percent of what White men are paid, and the 9.5 percent unemployment rate compared to 4 percent of White men (National Urban League, 2007).

DOUBLE JEOPARDY FOR BLACK MEN'S HEALTH

For African-American men, the challenge of a healthful change in lifestyle or behavior is compounded by long-standing social and historical conditions of inequality. The Sullivan Commission (2004) noted that the Civil Rights Era eradicated the more visible racial and ethnic barriers of the U.S. health care system, but today "institutional racism" is subtler and requires vigilant identification. Institutional racism is defined as a process of oppression, unconscious or not, functioning as "a system of structuring opportunity and assigning value based on phenotype ('race'), that unfairly disadvantages some, unfairly advantages others, and undermines the potential of the whole society" (Jones, 2003, p. 19).

As a result of these structural cycles of poverty, African American men who have lower levels of socioeconomic status are at a greater risk for negative health outcomes in part because they adhere more to traditional male gender role norms. Men are less likely than women to seek needed medical care in a timely manner or to follow medical advice (Staples, 1995; Helgeson, 1995). Research suggests that male gender role norms socialize men to believe they are invulnerable to illness or that asking for help, such as for medical problems, is a sign of weakness (Nicholas, 2000). Avoidance of health care providers by men has been offered as a partial explanation for the increased mortality rates from heart disease among men (Nicholas, 2000; Staples, 1995; Helgeson, 1995). However, what further complicates this story is socioeconomic position. Men in lower social positions also may conform more to traditional male role norms, which allows them to diminish their vulnerabilities (Powell-Hammond, and Siddiqi, forthcoming). These men also exhibit higher levels of medical mistrust. When African American men do report trust in the medical system, they are more likely to adhere to their treatment plans (Elder et al., forthcoming). Trust is a complex phenomenon that also requires ready access to social and cultural capital to cope with negative experiences that may result from discriminatory practices in their neighborhoods, workplaces and in the health care system.

These attitudes, beliefs, and behaviors resulting from an idealized view of masculinity are often associated with increased health risks for other health behaviors, which men in general engage in more compared to women. In a recent review of masculinity and the health of men of color, of the twenty-two studies reviewed, seventeen associations were positive, seven were negative, eight showed no association, and five showed conditional associations (Griffith et al., 2012). This suggests that a positive association with masculinity, or adherence to traditional male role norms, was positively associated with low-income men, who may be at increased risk for substance abuse because of the daily stresses they face and the socially sanctioned nature of substance use as a coping strategy for men. Also, many African American fathers, especially those living in urban environments, show 1.5 times more depressive symptomatology compared to the general population and report more co-morbid anxiety and substance use (Sinkewicz & Lee, 2010). It is unclear

if the structural barriers to African American men fulfilling the provider role leads to more mental health issues, as these men may see themselves as less than a man because of their inability to provide for their families (Ray 2008). Men with limited educational and employment opportunities may turn to alcohol and other drugs as an escape from their inability to live up to one of the major tenets of male gender socialization in our society (Bartholomew et al., 2002). Many African American men live in disadvantaged neighborhoods with high rates of crime, substandard housing, crowding and noise pollution (Adler & Snibbe, 2003) and environmental hazards (Bullard, 1990). Many of these men in their youth have attended schools in the poorest and most segregated public schools compared to other racial, ethnic and gender groups in the United States (Schott Foundation, 2006). These differences in gender-specific, learned behaviors are the major contributors to many of the health disparities between men and women (Courtenay, 2000).

African American men, who are economically and socially marginalized in society are more likely to exhibit forms of masculine power that are detrimental to their health, such as authority-defying behaviors to outwit others, toughness and violence, and sexual prowess. This suggests that gender is a socially constructed identity, that is acquired through what a person does in social interactions with other people and in their social context (Hearn, 1994; Moynihan, 1998). To manage the negative experiences African American men encounter on a daily basis, including racial discrimination, some theorists posit that African American men have developed a "cool pose" to cope and combat these experiences (Majors and Billson, 1992). In response to proactive police surveillance (or Driving While Black); workplace tensions, such as not holding positions of influence; and employment discrimination, cool pose provides a psychological or cathartic release from micro and macro aggressions resulting from daily experiences of racism. These behaviors help to deliver messages of strength and control to conceal insecurities and the lack of self-efficacy.

At least one study suggests that high status, college-educated Black men exhibit more romantic approaches in their heterosexual pursuits which are structured by "normative institutional arrangements" such community size and living arrangements (Ray & Rosow, 2010). African American men often exhibit these behaviors because they have access to little or no sources of social capital (Royster, 2003) that are afforded to their White male counterparts in the forms of professional and economic achievements (Courtenay, 2000). For example, Whitehead (2005) posits that African American men's health risks reflect an objective environment, which structures opportunities for and assigns value to men's economic capacity. Economic capacity provides the higher-income man ready access to "respectable" means to achieve status and power, whereas the lower-income man is forced to rely on "reputational" means that place him at higher risk for injury, illness and death (Whitehead, 2005). In sum, high rates of homicide, sexually transmitted disease and chronic illness among African American men can be explained, at least partially, by the influence of male gender socialization within the context of limited opportunities in a racialized context.

UNDERSTANDING THE URBAN CONTEXT: ENGAGEMENT, ASSESSMENT AND INTERVENTION

Researchers and practitioners alike in many ways are being called to better understand the social statuses of African American males, their access and use of health care services and health behaviors across the life course. Thomas and colleagues (2011) adapted and extended a health care disparities model that was originally developed by Kilbourne and associates (2006), which articulated three phases of health care disparities research. Thomas et al.'s (2011) model comprises four phases that seek to understand the origin of disparities to developing community-based strategies to eliminate those disparities. The first generation of health disparities research focuses on detection, identification and documentation of disparities. The "second generation" would determine causal relationships that underlie these disparities. "Third-generation" research provides solutions for eliminating health disparities. Finally, "fourth generation" research seeks to address structural determinants of health through comprehensive multilevel interventions that incorporate evaluation and self-reflection of the researcher. African American men's health research is primarily captured within the "first generation." The future of African American male health is to move research into generations two, three and four. Currently, quantitative and qualitative studies have illuminated the social, structural, community, family, and individual complexities of the African American male status. What is lacking is a more clear understanding of the causal relationships between the social determinants of health, and how researchers and practitioners can access community-level assets as a way to identify strategies within Black communities across the United States to ameliorate the range of inequalities that lead to disparities in health and social status. Moving into the fourth generation is critically important as we better understand how policy and structural interventions can and will not only redefine the Black male experience but will re-structure key opportunities for social and health improvement.

ENGAGEMENT AND ASSESSMENT

Xanthos, Treadwell and Holden (2010) suggest several changes within the policy arena and within health care systems to address the growing inequalities plaguing African American men. These include removing barriers to employment opportunities, improving high school completion rates, increasing minimum wage, providing more employer benefits, redressing sentencing biases in the criminal justice system, providing gender-specific health services, and improving the human capital in the health care workforce. No proposed strategy or effort will successfully eliminate health disparities without systematically engaging various communities of men in a sustained manner. Researchers and practitioners need to systematically engage communities to ascertain an insider's view by continuing the ethnographic research

Anderson (1999, 1990) began depicting developing social identities of urban males that emerged from historical roles and social positions of African American males in many Black communities. These new social identities have been reduced as a result of opportunity structures becoming constrained.

Many older African American males held lower-status jobs that did not offer advancement in the same ways as they did for White males. As a result, these men gained community clout through the social capital gained by participating in institutions such as Black churches and work-related unions. As more African American men have obtained some college education, they have been actively involved in 100 Black men or Greek-letter college fraternities which have provided additional opportunities for men to be civically engaged. However, we contend that this participation still remains marginal in light of the myriad of social and health ills that stifle the progress of African American males. Many of these safe spaces of churches, mason lodges, and fraternal societies capture some of the African American male population, but it does not capture all of African American male society. The growing interest in barbershop-based health promotion initiatives is a start because of the relationships men have with their barbershops and barbers (Kong, 1997; Hess et al., 2007; Victor et al., 2009; Releford et al., 2010; Victor et al., 2011; Ferdinand et al., 2012). More needs to occur to engage men in bars and lounges, pool halls, and at their places of employment, which are non-traditional and sometimes unsafe or unchartered spaces for community engagement.

A second approach is to assess community and organizational capacity for health promotion efforts. Assessing the capacity of African American communities and understanding the role key organizations and institutions can play to create opportunities to bring men together will create disease prevention and health promotion opportunities. Effective organizations and inter-organizational networks respond to both internal and external environments to build collectivities that are consciously constructed to realize purposeful joint action (Hanf & O'Toole, 1992; Lewin & Minton, 1986). The goal of this form of engagement and assessment is to identify community gatekeepers, key informants, natural or lay helpers, organizations, or segments of organizations such as men's groups in churches, or develop a social network of barbers who can help stand in the gap between early onset of disease, promoting healthy behaviors, encouraging the use of health care services, and identifying sources of health care services for under- and un-insured men.

Developing capacity can take on Crisp, Swerissen, and Duckett's (2000) four approaches to building capacity: a top-down organizational approach; a bottom-up organizational approach; a partnerships approach; and a community organizing approach. The partnership approach seeks to "strengthen the relationships between existing organizations," while a community organizing approach builds upon individual community members' formation of new organizations or joining with existing organizations (p. 100). The authors describe providing financial and human capital and other resources to organizations with the goal of enhancing their ability to identify, analyze and address their needs. This is largely lacking in both research

and practice pertaining to the dire challenges many African American males face. Overall, this approach recognizes that communities have existing assets, in the form of individuals, networks and organizations, or recognizes the need for them to be enhanced. Ultimately, assessing and enhancing the capacity of communities and organizations has the potential to lessen the deepening sense of precarious manhood (Vandello et al., 2008) of African American men, which often leads them to engage in risky health behaviors to prove their manhood.

We can assess community and organizational capacity qualitatively and quantitatively to understand the role the intersection of race, gender, and social and physical environments in shaping the poor health and social status of African American males. Tools and methods for assessment should include ethnographic approaches such as participant observations. Participant observations (PO) are qualitative methods that "allow you to get close to people" (Gans, 1999). Gans (1999) also describes that other empirical methods rely on what people "say" about what they do, whereas participant observation allows the researcher to "observe" what people do. Participant observations are one technique that is based on the idea that individuals draw from common experiences to develop their cultural perspectives (Drury, 2008). Additional methods such as in-depth interviews and/or focus groups can become a key part of the iterative process (Family Health International, 2005). The key components of PO include the following: 1) observing people as they engage in activities; 2) engaging in the activities being observed; 3) interacting with individuals outside of the controlled research environment; and 4) identifying and developing relationships with key informants, gatekeepers, and stakeholders (Family Health International, 2005). The implication for public health interventions would be to identify men who have overcome the chronic societal pressures and challenges of their social and physical environments and engage them as advisors and mentors to men in their social networks through community service, goal setting, discipline in achieving goals, and the integration of body, mind, and spirit (Aronson et al., 2003; Whitehead, 2005).

One of the most important opportunities to address the inequalities in African American men's health is to understand the functional significance of racial and gender identity and how these intersecting identities limit access to power and desired resources in society. It is important for interventions to move away from a biological construct of race and gender and rather focus on the social constructions of race and gender and consider how these exert powerful influences on behavior and lifestyle as reflected through cultural belief systems and social norms without the individual being aware of the determinants. Deviations from population norms, such as relative poverty or discriminatory access to services, are problematic because they may put certain groups at risk and affect individual health. These relationships are expressed by a range of psychosocial variables which themselves are predictive of morbidity and mortality, including low self-efficacy, depression, limited optimism and control over life events, and heightened anger and hostility (Hakstian & McLean, 1989; Pearlin, Lieberman, Menaghan & Mullan, 1981). Interventions should focus on differential

treatment of African American men in health care settings, understanding changing notions of African American manhood across the lifecourse and how these notions are shaped by social factors, and developing culturally targeted health messages to address disease prevention and health promotion efforts. Important components of these interventions should include collaboration with community-based organizations, enhancing social support and social capital through social networks, improving educational attainment, and policies that support workforce development.

CONCLUSION

The performance of masculinity within the United States has many negative health implications for African American men. Many African American men have been systematically disengaged from systems of care and local, national and federal safety-net programs, they have rejected institutions that are seen as feminine, such as schools, and they are not afforded the same structural opportunities as White men. A concerted effort from all segments of the community is needed to address the complex and dynamic social and health crises faced by African American males.

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18

Economic Contractions' Neglected Impact on African Americans' Mental Health

Lonnie R. Snowden and Tim A. Bruckner

The world economy remains mired in the 2008 recession at the time of this writing, with troubling economic, social and political ripples cascading worldwide. The present recession's tragic consequences affect everyone, but for members of certain populations—including citizens of Greece and Ireland (Lewis, 2011) and, as will be demonstrated, for African Americans—the economic and social consequences have proven especially dire. As lives are transformed by economic adversity and the resulting financial and psychological strains, and by lost therapeutic and support opportunities for persons with mental disorders (Hodgkin & Karpman, 2010), the recession will very likely count higher rates of mental illness among its detrimental consequences.

The great recession's preceding shock was severe, but lesser shocks are regular features of economic life. The bursting Internet bubble and post-9/11-related economic declines were shocks of lower magnitude, but they were sufficient to send destructive aftershocks throughout the economy. More common still are ordinary downturns that occur as part of routine declines in the economic cycle which, research indicates, are sufficiently disruptive to cause mental-health-related distress. Whether economic decline takes the form of an ordinary downturn or a shock, there is good reason to believe that mental illness in affected populations rises (Goldman-Mellor, Saxton & Catalano, 2010).

Among the populations affected by economic adversity, one of the most affected are Black citizens of the United States. As we show, African Americans' continuing state of poverty is matched by their economic precariousness and responsiveness to adverse economic events. African Americans' economic circumstances have declined in the current recession more quickly and more severely than those of whites. Economic downturns matter especially for African Americans and, there is reason to believe, for African Americans' mental health.

A wider epidemiologic literature on economic well-being and mental health documents links between socioeconomic status and overall level of mental illness (Yu & Williams, 2005). This literature is heavily weighted toward cross-sectional studies of mental illness prevalence. By contrast, to focus on economic contraction, including shocks—that is, unexpected, societywide crises marked by precipitous economic decline—and on the link to mental illness, is to focus attention on mental illness's incidence rather than on its prevalence. We believe that examination of economic contraction and shock, rather than static descriptions of prevalence, may uncover important, previously overlooked determinants of American Americans' mental illness. The unexpected nature of most contractions, shocks especially, may elicit personal and societal responses not predicted by research on prevalence.

Viewed in cross-sectional perspective, despite exhibiting higher rates of poverty and illness and greater exposure to other risk factors, African Americans have been shown to suffer from levels of mental illness no higher than those of whites (Breslau, Aguilar-Gaxiola, Kendler, Su, Williams, & Kessler, 2006). This counterintuitive finding has been questioned and, in some quarters, it has engendered doubt (US Department of Health and Human Services, 2001). What is most important to grasp for present purposes, however, is that the predominant cross-sectional perspective cannot address inherently dynamic questions, including whether African Americans' mental health is especially responsive to economic shocks and if so, how.

In this chapter we begin by demonstrating, from a limited but convincing research literature, that African Americans are more responsive than whites to economic contraction and shocks. We then show how this greater vulnerability may lead African Americans to respond with new or recurrent mental illness and treatment seeking. We then provide several plausible reasons, including the greater likelihood of poverty, why, in theory, African Americans' mental illness and treatment seeking will rise more than whites' during times of economic adversity. We next lay a foundation to claim that, because of greater reliance on safety net programs and for other reasons, African Americans with mental illness will receive disproportionately less treatment and less adequate treatment when the economy contracts. Finally, we give reasons to believe that African Americans' mental-illness induced difficulties in successful social and economic functioning may be exacerbated especially, perhaps increasing African Americans' overrepresentation among homeless persons, persons confined in jails and prisons and other high-need populations. Our focus is on mental illness meeting official psychiatric diagnostic criteria and on mental illness's symptoms as reflected in widely accepted checklists and rating scales.

ECONOMIC CONTRACTION AND SHOCK, AFRICAN AMERICANS, AND MENTAL ILLNESS

An ongoing pattern of cyclic economic increase and decline is punctuated by periodic catastrophe, as illustrated by economic crises of 2008. The threatened collapse

of the worldwide banking system, with untold economic consequences, was precipitated, among other factors, by the unexpected crashing of real estate prices and by the collapse in value of other assets (Jickling, 2010). These devastating events provide a still-open window for viewing shocks and the economic ripples they engender as they affect African Americans. Economic shocks' mental-health-related impact has been carefully studied in a small but convincing research literature, which includes studies of African American–white response disparities.

African Americans' Pronounced Response to Economic Contraction and Shock

African Americans' response to the 2008 great recession and the economy's subsequent halting recovery demonstrate a differential African American–white response, a consequence of African Americans' precarious economic grip. Between 2009 and 2012 household incomes declined for everyone, but Black household income declined more than that of whites. Black household income declined by 11.1 percent, whereas white household income declined by 5.2 percent (Sentier Research, 2012).

African Americans' greater loss of income was matched by their loss of a principal income source: employment. On a survey of randomly sampled adults, African Americans reported more job loss than whites (Perron, 2010). As would be expected, African American unemployment, too, rose more sharply than white unemployment (Lopez & Cohn, 2011). This disparity in job loss and unemployment may arise, in part, from the higher concentration of African Americans in service, manufacturing, and construction sectors, all especially hard hit in the downturn (Wessler, 2009).

African Americans also reported greater exposure to consequences of income loss and to other sources of economic misfortune. Following the great recession's onset, African Americans indicated that they encountered more difficulty in paying expenses and in meeting mortgage payments and paying rent (Perron, 2010). African Americans especially suffered mortgage foreclosure: By one estimate, among 2007 to 2009 mortgage borrowers, about 7.9 percent of Blacks were foreclosed versus 4.5 percent of whites (Bocian at al., 2010).

Two decades ago, the National Research Council, in its comprehensive report on African Americans, pointed to several factors—affirmed in studies of African Americans' response to the great recession—which explain the disproportionately adverse African American response to economic misfortune. According to the National Research Council: "Blacks are disproportionately employed in low-wage jobs, unprotected by tenure and seniority, and in manufacturing and other goods-producing industries that are particularly sensitive to the business cycle." For these reasons, the Council concluded: "Blacks are acutely sensitive to the expansions and recessions of business cycles" (Jaynes & Williams, 1989, p. 294).

Economic Contraction and Shock and Mental-Illness-Related Response

An important but neglected research literature lays a foundation of evidence indicating that mental illness increases in response to economic contractions and

shocks. Goldman-Mellor, Saxton, & Catalano (2010) reviewed studies published between 1990 and 2009 focused on understanding whether the onset of economic contraction is linked with the onset of psychological problems, including mental illness. After sorting the literature and critically evaluating it, they concluded: "Most researchers agree that involuntary job loss increases the risk of psychiatric disorder and somatic sequelae. Much research has established a strong correlation between job loss and clinical and subclinical depression, anxiety, substance abuse, and antisocial behavior. Longitudinal panel studies have suggested that job loss tends to precede the onset of psychiatric disorders, although selection bias clearly contributes to the correlation" (Goldman-Mellor, Saxton, & Catalano, 2010, p. 7).

Findings from cross-sectional research suggest that acute economic stress is especially detrimental to African Americans' psychological well-being (Ennis, Hobfoll, & Schroder, 2000). Findings from large sample, longitudinal research support this preliminary conclusion. Studying emergency responses to psychiatric crisis, Catalano, Novaco & McConnell (1997, 2002) reported that as unemployment rates rise and fall, so do rates of use of the emergency room for involuntary treatment of persons with mental illness. Testing a potential differential African American–White response, Catalano, Snowden, & Shumway (2005) showed that African American males appeared in psychiatric emergency services even when they were functioning, for mental illness and social-adjustment purposes, more successfully than others. The finding pointed to the possibility that lower levels of tolerance for mental-illness-induced misbehavior by African American males yielded more psychiatric emergency intervention. Studying Medicaid-insured children, non-participants in the labor force themselves who nevertheless are affected by job loss and economic stress affecting their often-employed caretakers, Bruckner, Kim, & Snowden (2012) demonstrated that a contracting economy precipitated more children's use of psychiatric emergency services and that the increase was true especially for African American children.

Two conclusions emerge from the literature reviewed above. First, the evidence accumulated to date indicates that economic downturns are associated with growing rates of mental illness and substance abuse. The evidence also indicates that African Americans are especially likely to experience higher treatment rates for urgent mental disorders in response to economic contraction and shock.

HYPOTHESES FOR EXPLAINING AFRICAN AMERICANS' GREATER VULNERABILITY TO ECONOMIC CONTRACTION AND SHOCK

African Americans disproportionately are poor, but both poor and non-poor African Americans have a precarious hold on whatever economic and social well-being they attain. They have less economic and social margin to absorb economic contraction and shock, and they are more reliant on public-supported safety net programs whose financing can be threatened during times of economic difficulty.

African Americans' Lesser Wealth

When the economy contracts, individual's personal financial circumstances often falter. Meeting what has become hard-to-meet financial demands is made easier by possessing a larger store of "total wealth." Total wealth consists of the aggregate value of home ownership, savings and investments and other financial assets (Keister & Moller, 2000). Total wealth serves as a financial building block for the accumulation of more assets and shelters families against temporary financial misfortune. Borrowing against the value of an owned home or home that is being purchased, borrowing from or cashing in investments, and other options are available to possessors of greater total wealth. These financial options are limited among lower-income groups and among African Americans at all income levels (Shapiro, 2004).

Concerned with assessing total wealth's health-related consequences, Bond, Kruger, Rogers, & Hummer (2003) investigated total wealth's impact on mortality, examining how much African American–White total wealth disparities explained mortality disparities. They found that total wealth disparities did contribute to explaining disparities in mortality, and they concluded that "vastly lower asset holdings among blacks, compared to whites, not only affects their financial well-being but also their survival prospects" (Bond, Kruger & Hummer, p. 667).

African Americans possess far less per capita wealth than whites, and the magnitude of this disparity dwarfs the African American–White income disparity (Shapiro, 2004). Existing total wealth disparities grew to even higher levels with the great recession's onset, as differential home ownership losses exacerbated total wealth disparities. From 2005 to 2009, inflation-adjusted median wealth declined by only 16 percent among White households but by 53 percent among Black households (Lopez & Cohn, 2011).

Increasing Stress and Decreasing Opportunity from Residence in Disadvantaged Neighborhoods

African Americans are considerably more likely than whites to live in disadvantaged neighborhoods, and considerable evidence establishes that disadvantaged neighborhood's residents are at heightened risk for health-related adversity (Kawachi and Berkman, 2003). Several reviews of literature affirm that disadvantaged neighborhood residence is linked with mental illness, especially depression (Kim, 2008, Mair, Diez Rouz, & Galea, 2008; Paczowski & Sandro, 2010). African Americans living in disordered neighborhoods have been shown, in particular, to be at risk for mental illness (Shultz, Williams, & Israel, 2000; Hastings, Snowden, & Kimberlin, 2012).

Neighborhood disadvantage is disaggregated into two components: (1) social disorder and (2) economic and social deprivation. Social disorder refers to the breakdown of social structures and social processes that maintain public order, civility, and safety. Unchecked illegal activity and poorly maintained property signal societal disregard and abandonment, and they can promote residents' sense of alienation

from mainstream society (Taylor and Hale, 1986). Social disorder promotes antisocial norms and signals license for otherwise unacceptable conduct, and it often leads residents to perceive their environment as disorganized and threatening (LaGrange et al., 1992). The stress of negotiating daily life in such an environment, knowing that basic protections are lacking and that neighbors cannot be trusted, may trigger feelings of pessimism, helplessness and depression (Aneshensel and Sucoff, 1996; Ross, 2000).

Social disorder can thrive in the absence of countervailing, pro-social norms, such as pro-social inclinations characterizing "collective efficacy" (Sampson, Raudenbush, & Earls, 1997). Neighborhood residents' willingness to support each other and to take collective action on behalf of the neighborhood order and safety—hallmarks of collective efficacy—may decline in response to economic contraction and shock. In a study of non-economy-induced social adversity, researchers reported that more crime reduces neighborhoods' social cohesion—although greater social cohesion reduces neighborhoods' affliction with crime. Because they are more fearful, neighbors in crime-ridden neighborhoods—and perhaps neighbors living through a contracting economy—inadvertently behave in ways that undermine social cohesion (Markowitz, Bellair, Liska, & Liu, 2006).

Neighborhood disadvantage's second dimension, neighborhood economic and social deprivation, refers to disadvantaged neighborhood's providing few jobs and offering low-quality schools, low-quality housing, and few recreational opportunities (Sooman and Macintyre, 1995). Residents' deprivation due to an impoverished neighborhood can also include outsider's negative personal responses, especially outsider's unwillingness to trust poverty neighborhood residents. Kirschenman and Neckerman (1991) found that employers in the Chicago area discriminated against applicants with addresses in "bad" neighborhoods, and that residents were less likely to be offered employment because they were believed to be less reliable and productive.

Becoming more "risk averse" in a shrinking economy, employers may be less inclined to hire and more inclined to fire people whose residential circumstances bring to mind questionable habits and dubious personal connections. This added employer mistrust of residents from disadvantaged neighborhoods arises from insecurity brought on by economic misfortune. The new reaction compounds ongoing neighborhood-based and race-based negativity and can cause poor African American neighborhoods' residents to lose employment they already hold and not to be hired for new employment, whatever their personal qualifications and character strengths.

Decreasing Social Support from African Americans' Already-Burdened Social Networks

Between economic contractions and shocks, demands on social support in African American networks may be greater than they are for other groups. Obligations for assistance with childrearing, elder care, and other forms of nonmaterial aid must be

fulfilled by a smaller number of caregivers shouldering many competing responsibilities and possessing little financial capacity to purchase substitute care (Rochelle, 1997).

During economic reversals, family members' and friends' capacity to assist each other, through material assistance and by providing increasingly needed social support, may further be reduced. As they are when enacting their roles as neighbors, African Americans' family members and friends in disproportionate numbers can become preoccupied with newly pressing personal concerns, thereby becoming less available for socially supportive gestures on behalf of valued significant others. Researchers have demonstrated how non-job-losing, potentially supportive significant others are affected by a partner's job loss via "stress transmission" (Rook, Dooley, & Catalano, 1991), potentially rendering the stressed partner less capable of providing needed support.

In African American networks, already burdened supportive figures may be unable to meet newly emerging needs of family members and friends at risk for a first or recurrent episode of mental illness or who already are mentally ill. One study of African Americans nationwide found that social support declined for persons in need in response to financial strain, which presaged negative social interaction with relatives and, ultimately, more symptoms of depression (Lincoln, Chatters & Taylor, 2005). When the economy declines and financial strain increases, interactions with friends and family members can become sources of strain more than sources of support, and African Americans may be especially affected.

Increasing Strain on Publicly Financed Treatment

Like other low-income people, African Americans rely on safety net programs for economic, social and medical assistance. Safety net program's financing is sensitive to economic crises because, in response to economic setbacks, the demand for services can grow population wide, even as policymakers, concerned about their increasing budgetary commitments and decreasing revenues, seek to restrain safety net program's costs (Hodgkin & Karpman, 2010; Poterba, 1994; Bohn & Inman, 1996; Barrilleaux & Miller, 1988). Resource restrictions can exacerbate mental illness of vulnerable safety net program participants, including African Americans who are overrepresented in safety-net programs.

Among safety-net programs, the federal-state Medicaid program is especially important as a vehicle for treating African Americans' mental health problems. Medicaid is very large (The Kaiser Commission, 2007), and Medicaid plays a dominant role in mental health treatment financing (Frank, Goldman, & Hogan, 2003): Presently, Medicaid is the leading payer for mental health treatment in the United States (SAMHSA News, 2005). Because they are more likely than others to live in poor and "near poor" families, African Americans are more than 2.5 times more likely than whites to have insurance coverage through Medicaid (De Navas-Walt, Proctor, & Smith, 2010).

Medicaid finances mental health treatment for several safety-net programs in which African Americans participate in disproportionate numbers. Temporary Assistance for Needy Families (TANF), a federal-state partnership and the primary cash assistance program for families in financial distress, is charged with preparing non-self-supporting participants for independence by entering the world of work (Office of Family Assistance, Temporary Assistance For Needy Families, 2009). Mental illness is more prevalent among TANF recipients than among others, and mental illness limits TANF participants' capacity to work (Hastings & Snowden, 2012; Pavetti, Derr, Kauff, & Barrett, 2010). Inability to treat mental disorder among TANF recipients, therefore, undermines TANF's program goals.

Timely treatment of mental health problems can help participants become employed before their eligibility for TANF support comes to an end. Because mental illness is so disabling (Kessler et al., 2003), mentally ill TANF participants are particularly in need of mental health treatment to successfully make the transition to work—especially in a contraction or shock-induced, shrinking labor market. Mental health treatment for TANF participants is Medicaid financed, and it is subject to pressure for reduction during economic downturns affecting other Medicaid-financed services.

When children are suspected of having been abused or neglected, their families come to the attention of child protective services officials. Ultimately, such children may be removed from their homes and placed in foster care. African American children are especially affected. They are considerably overrepresented among children placed in, and remaining for lengthier stays in, foster care (U.S. Department of Health and Human Services, 2010).

Psychological distress and mental illness are widespread among children referred to child protective services. Among children placed in foster care almost 42 percent suffer from a DSM-IV disorder (Garland et al., 2001), and foster care mental health treatment rates are considerably higher than treatment rates in the population at large (Burns et al., 2004). As economic conditions deteriorate, child welfare placement rates increase (Catalano, Lind, Rosenblatt, & Attkisson, 1999) and children's mental health service use rises (Bruckner, Snowden, Subbaraman, & Brown, 2010). At the same time, Medicaid-based treatment resources are threatened and may decline.

Hodgkin & Karpman (2010) examined mental-health-related policy responses to economic crises around the world extending as far back as the Great Depression. In response to the current great recession, they found that, in most states, large mental health budget cuts were contemplated or enacted, thereby reducing resources available for treatment. They concluded that: "Cuts to state mental health-care budgets will most certainly impact access to mental health care" (p. 97). However, they also found that mental-health-related budget cutting was not inevitable. Some countries were shown to increase their mental health spending in response to economic crisis and growing treatment need.

During the current recession and perhaps during other contractions, as the demand for Medicaid-financed mental health care grows, publicly supported treatment

resources appear to shrink. We expect that under-treatment of mental illness will increase, especially among African Americans who disproportionately rely on publicly financed care, and the incidence of persons with unmanaged psychiatric symptoms and severe social disability will grow.

Increasing Rates of Untreated and Inadequately Treated Mental Illness

Increasing pressures on the capacity to provide Medicaid-financed treatment in response to economic downturns, as well as greater demand for care throughout the mental health treatment system, will likely increase already high African American–white disparities in treatment access and quality of mental health care. Existing treatment disparities are large. National estimates of African American–white disparities indicate that only 10.1 percent of African Americans versus 17.9 percent of others, and 31.9 percent of African Americans meeting DSM-IV criteria versus 41.1 percent of others were treated (Neighbors et al., 2007).

In addition to lower levels of adequate treatment, trends toward growing treatment rates society wide do not favor overcoming African American–white treatment disparities. Cook, McGuire, & Miranda (2007) found that African American–white American treatment disparities grew between two estimation points, 2000 to 2001 and 2003 to 2004. Over this short interval, African American treatment rates detectably increased more slowly than white treatment rates.

This growing disparity in treatment access is compounded by the lower quality of treatment African Americans receive when they receive any treatment. Estimates indicate that, nationwide, 32.7 percent of treated persons receive minimally adequate care, whereas only 21.2 percent of African Americans receive minimally adequate care (Neighbors et al., 2007). Focusing on a high need sample, persons with serious mental illness, Wang, Demler, & Kessler (2002) reported that 19.4 percent of treated, seriously mentally ill African American persons received minimally adequate treatment, whereas 37.6 percent of treated white Americans received minimally adequate treatment.

Several factors account for this African American–white gap in treatment access. Stigma, which prevents mentally ill persons from recognizing and labeling mental illness as such and seeking appropriate care (Anglin, Link, & Phelan, 2006), may be especially prevalent among African Americans (Alvidrez, Snowden, & Patel, 2010). Mistrust of mental health programs and providers, which characterizes African Americans' views of general health care programs and providers (Leask & Snowden, 2012), applies to African Americans with mental illness as well as to African Americans at large (Whaley, 2001). African Americans' mistrust may dissuade mentally ill African Americans from seeking needed care. A paucity of culturally sensitive programs and providers, who provide a welcoming atmosphere and which employ clinicians who understand the special needs of African Americans with mental illness, may further discourage mentally ill African Americans from treatment seeking and prevent delivery of high-quality care (Snowden & Yamada, 2005).

No data are available to address the issue, but we speculate that stigma and mistrust do not decline during economic contractions; the more likely prospect we believe is that they grow. Programs and providers tailored to African Americans' mental health needs likely do not increase during economic contractions—conceivably, their numbers decline. African Americans' treatment rate increases have failed to keep pace with those of whites (Cook, McGuire, & Miranda 2007). Furthermore, if African Americans' mental illness increases during economic contractions, then rates of untreated mental illness may increase and African American–white disparities may grow toward levels even greater than now.

INCREASING AFRICAN AMERICANS' INADEQUATELY AND UNTREATED MENTAL ILLNESS AND INCREASING THEIR LONG-TERM DISABILITY

Mental illness can disable mentally ill persons, and African American mentally ill persons are especially likely to suffer from mental illness–related disability in longer-lasting and more severe forms. As treatment and social infrastructure deteriorate in response to economic contraction, persons who are more severely disabled can suffer mental illness's most distressing social outcomes, African Americans disproportionately more than others.

Increasing Mental-Illness-Related Severe, Long-Term Disability

Considerable evidence documents a link between suffering from mental illness and being unable to function successfully in everyday life. More than half of persons suffering from depression cannot, because of mental illness, function as well as others in meeting family, social, and community responsibilities: 59 percent were determined to suffer from severe or very severe role impairment (Kessler et al., 2003). Mental illness disability also contributes to pressures toward downward social and economic mobility of persons who are severely and persistently mentally ill (Dohrenwend, Levav, Shrout, Schwartz, Nevah, Link et al., 1992).

Particularly striking among the disabling effects of mental illness is how mental illness suppresses personal earnings. Kessler et al. (2008) demonstrated that for persons suffering from a serious mental illness during the preceding twelve months, income loss could be calculated at $16,306 for everyone who was seriously mentally ill and $14,393 for persons reporting any earnings. The estimated loss to society as a whole was $193.2 billion.

African Americans' mental illness may be particularly enduring and disabling. Among persons suffering from Major Depressive Disorder (MDD), chronic MDD was about 57 percent for African Americans and 56 percent for Caribbean blacks versus 39 percent for whites (Williams et al., 2007). African Americans who met

criteria for anxiety disorder also experienced higher levels of mental illness severity and functional impairment compared to white Americans (Himle, Baser, Taylor, Campbell, & Jackson, 2009).

Mental-illness-induced disability appears greater for African Americans than whites, and disability's impact may be especially detrimental when the economy contracts. As discussed previously, fewer resources are available to support the stabilization of symptoms and functional rehabilitation, thereby promoting relapse into mental illness and extending durations of illness episodes and preventing recovery from mental illness. These problems may affect African Americans more than others because of African Americans' ongoing illness duration and severity which are greater than those for whites.

Among the most disabled and least supported mentally ill persons are persons susceptible to homelessness and incarceration. African Americans are overrepresented in these high-need populations (U.S. Department of Health and Human Services, 2001), and, under economic contraction and shock, this overrepresentation can grow. This growth may occur because African Americans with mental illness are especially severely disabled, and because they are less likely to receive needed treatment and to receive the informal support necessary to prevent functional deterioration and the most dire social consequences.

CONCLUSION

In the African American mental health literature, socioeconomic stratification has received considerable attention from theorists and researchers as they disentangle class-based versus race-based sources of African American–white disparities. Less inquiry has focused on what happens in the face of economic decline, overlooking long-standing indications that African Americans greater economic fragility leaves them especially vulnerable to economic contractions and shocks.

The great recession in which we find ourselves presently puts on display African Americans' greater vulnerability to economic contractions and shocks. When the economy contracts severely, African Americans lose their jobs, undergo financial hardship, and suffer a greater debt burden than do whites. These stressful events befall African Americans especially—above and beyond stressful effects from African Americans' already strained financial and social resources.

The publicly financed treatment systems on which African Americans disproportionately depend will also suffer under newly emerging economic downturns. It is likely that greater demand on treatment capacity conspires with ongoing sources of African American–white mental health treatment access and quality disparities to enlarge the disparities as economic decline persists. The greater severity and duration of mentally ill African Americans' mental illness episodes will likely drive disproportionately more African Americans into the most severe forms of mental-illness-related social disability with distressing legal and social consequences.

Further research is necessary to paint a complete picture of economic contraction and shock's consequences for African Americans' mental health. Investigators must seek precise estimates of channels through which African Americans' response to economic shocks transmit deleterious effects to African Americans' mental health. These estimates would ideally reconcile two observations: that the general prevalence of mental disorder among African Americans remains relatively low but that their reactivity to economic shocks is stronger than other racial and ethnic groups. We further note that several of the explanations described above are hypotheses awaiting rigorous empirical testing before they are taken to demonstrate true cause-effect relationships. We—unfortunately—anticipate that current precarious economic circumstances may provide new possibilities for research inquiry into our hypothesized explanations.

Challenges must be confronted if we are to fully advance this important research agenda. Economic conditions and mental illness must be studied as co-varying longitudinal events, since health responses may be both acute and delayed. Furthermore, prolonged downturns, rather than temporary dips in the economic cycle, may elicit fundamentally different coping responses among African American families. Understanding the potentially varied reactions to short relative to sustained downturns warrants more attention from researchers.

In addition, these associations must be estimated free of effects from "autocorrelation" of mental illness—a tendency of events occurring closely in temporal sequence to be correlated from one observation point to the next for reasons unrelated to economic downturns. The presence of correlated mental health observations rules out many conventional statistical methods, whose use rests on an assumption that observations as varying time points are independent from each other. Methods less familiar to epidemiologists but widely used in economics (e.g., Auto Regressive Integrated Moving Averages, "ARIMA") surmount this temporal patterning problem and exploit opportunities present in time-series data to provide rigorous estimates of associations. We expect that these and related methods, which examine the incidence of mental illness over time, will support stronger claims to internal validity than usually can be made from cross-sectional correlational studies.

Furthermore, we know little at present about the severity of economic adversity necessary to confer elevated levels of risk. We also have limited information on the time lags necessary before adverse economic events lead to adversity and greater risk of disorder. Addressing these and other concerns will provide much needed evidence on questions of exactly when and how economic contractions and shocks affect African Americans' mental illness and mental health.

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19

Urban Poverty and Cardiovascular Disease Health

Tekeda F. Ferguson and Nkenge Jones-Jack

The World Health Organization (WHO) in 2010 reported that more than 50 percent of the population of the world lives in an urban area, and that by the year 2050, approximately 70 percent of the world's population will be living in towns or cities. Urbanization has represented a major demographic shift particularly in the developed world. Urban living offers many people opportunities including potential employment options, access to better health care and education, and social and political mobilization. However, today's urban environments can concentrate health risks and introduce new hazards (WHO, 2010; World Heart Federation, 2012). The increased shift to urbanization of many countries in the developing world has increased mortality from infectious diseases to chronic and lifestyle-related diseases, such as cancer and cardiovascular disease (CVD) (Allender, Foster, Hutchinson, & Arambepola, 2008).

When urban environments are poor, they are settings that are rich in poor health outcomes. The rise of CVD in low- and middle-income countries has been linked to progressive urbanization and the parallel adoption or "globalization of unhealthy lifestyles," which are facilitated by urban life, tobacco use, unhealthy diets, physical inactivity and unhealthy use of alcohol (WHO, United Nations, Habitat for Humanities, 2010). One in 398 Americans died of cardiovascular disease in 2007 (American Heart Association Statistics Committee and Stroke Statistics Subcommittee, Roger et al., 2012). This constitutes almost one of every five deaths. The influence of pop culture, the mass media, marketing, the accessibility of unhealthy food choices, and wide accessibility to automation for transportation have had changes on the population's lifestyle that directly affect health (WHO, 2010). Foods high in salt, sugar, and fats are often less expensive to make and to offer, and are readily more available than fresh fruit and vegetables. Individuals who reside in urban settings face physical activity limitations including lack of planned space, crime, and heavy and

dangerous traffic (WHO, United Nations, Habitat for Humanities, 2010). Thus, CVD is not just an issue of lifestyle and individual behavior choices; the environment deters prevention and promotes chronic disease risk factors, allowing major health impacts and health disparities in rural and urban communities to occur.

In the full spectrum of the life cycle, effects of poverty are seen in the rates of chronic disease in the population. Poverty affects people and their risk of chronic disease and cardiovascular development before and after birth. There is increased support in the literature that the health of the mother before and during pregnancy has direct implications on her child's future health. Atherosclerosis plaques (i.e., hardened arteries) have been identified in young children, revealing that CVD starts long before there are clinical manifestations with outcomes (Berenson, Wattigney, Tracey, Newman, Srinivasan, Webber, Dalferes, & Strong, 1992). CVD risk is also known to increase in age, and over 80 percent of the population above the age of eighty has CVD (Roger et al., 2012).

The chapter begins with a description of the epidemiology of CVD, followed by the definition and classification of CVD. Epidemiology gives the perspective of person, place, and time, and as causation and prevention are discussed and considered, CVD has to be focused in terms of these classic characteristics. A discussion of the socioeconomic factors linked to CVD incidence and mortality is included, which explore the place characteristics highlighting environmental factors. The chapter ends with a synopsis of how these links are understood and critical issues that should be addressed in strategies for CVD prevention.

EPIDEMIOLOGY OF CARDIOVASCULAR DISEASE

Epidemiology is the study of determinants and distributions of human diseases and is considered central in reducing the burden and disparity of cardiovascular disease (CVD) (Labarthe, 2011). CVD epidemiology, the study of the determinants and distribution of diseases of the heart and blood vessels, has extensively contributed to a considerable amount of knowledge about the causes and means of prevention of CVD and related conditions; but the knowledge has yet to be utilized on an ample scale to produce its "potential societal benefit" (Labarthe, 2011). CVD is still the number-one cause of morbidity and mortality in the United States and the world.

Distributions of CVD

There is variation in rates of CVD by age, sex, race, and geography. One in less than three Americans will be diagnosed with cardiovascular disease in their life time: 1 in 2.67 White men, 1 in 2.23 Black men, 1 in 2.96 White women, and 1 in 2.11 Black women will be diagnosed with cardiovascular disease (Roger et al., 2012). The 2008 death rates were 287.2 per 100,000 for White males, 390.4 per 100,000 for Black males, 200.5 per 100,000 for White females, and 277.4 per 100,000 for Black

females (Roger et al., 2012). Data from the 2007–2008 National Health and Nutrition Examination Survey (NHANES) reveal that overall, 6.6 percent of Americans self-reported having CVD: 2.8 percent reported having coronary heart disease; 2.6 percent reported having a stroke; 2.0 percent reported having congestive heart failure; and 2.7 percent reported having a heart attack. From 1998 to 2008, the death rate from CVD declined 30.6 percent (Roger et al., 2012). However, CVD remains the leading cause of morbidity and mortality, and the risk factors for disease are presenting clinically in younger ages. Knowing these statistics could cause alarm, it does for individuals that work in public health and health care. In people who are not affected, the statistics incite questions. For those whom the statistics are describing, there can be a sense of indifference or inevitability. To understand the impact of urban poverty and CVD on population health, the definition and classification of CVD should be reviewed.

Classification of CVD

Cardiovascular disease (CVD) is defined by a classification of diseases that involve the heart and circulatory system that supplies blood to the heart, brain, and peripheral tissues. Cardiovascular disease categorizes disorders including hypertension, rheumatic and ischemic heart disease, cerebrovascular disease, atherosclerosis, and congenital abnormalities of the heart and circulatory systems (WHO, 1992). There are ten International Classification of Disease (ICD) code classes that are used to categorize cardiovascular disease (table 19.1).

The ICD-10 codes are the most up-to-date revision; however, ICD-9-clinical modification codes are still on hospital discharge data and ambulatory care visit data. For the ICD-10 codes, each two-digit code beyond the letter "I" corresponds to a subset of that CVD class of diseases, and a decimal place code can be added to

Table 19.1. International Disease Classification Codes for Cardiovascular Disease Ninth revision and Tenth Revision.

ICD-10	*Disease/disorders*	*ICD-9*
I00–I02	Acute rheumatic fever	390–392
I05–I09	Chronic rheumatic heart diseases	393–398
I10–I15	Hypertensive diseases	401–405
I20–I25	Ischemic heart diseases	410–414
I26–I28	Pulmonary heart disease and disease of pulmonary circulation	415–417
I30–I52	Other forms of heart disease	420–429
I60–I69	Cerebrovascular diseases	430–438
I70–I79	Diseases of arteries, arterioles, and capillaries	440–449
I80–I89	Disease of veins, lymphatic vessels, and lymph nodes, not elsewhere classified	451–459
I90–I95	Other and unspecified disorders of the circulatory system	
Q20–Q28	Congenital anomalies of heart and circulatory system	745–747

provide more detail. ICD codes are widely and commonly used, but the reliability of the data depends on the coder or coding procedures. Over time the quality of ICD codes have improved with the wider use of the codes by multiple entities and for billing purposes. This provides the opportunity for different cross checks of the data. However, random and systemic errors still occur. All of the categories of CVD can be found at a number of urban hospitals. The CVD ICD codes represent disease outcomes, and unfortunately, when these disorders present at a clinic or hospital, the disease process is well underway. Procedures and treatments can begin for secondary and tertiary prevention, but the primary prevention stage, the least costly, has been passed. ICD codes are not known by patients or deemed important for them to be aware of; but the codes are used to determine services that are allowed to be reimbursed by insurance and help paint the picture of disease and symptoms in the population.

Beyond ICD codes, individuals are sometimes categorized by their potential risk. The Framingham Risk Score is used by physicians in the United States to define a person's ten-year risk of having a heart attack (National Cholesterol Education Program, Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults [Adult Treatment Panel III], 2002). The Framingham Risk Score was developed from data from the longest running follow-up study of heart disease, the Framingham Heart Study. The ten-year risk is calculated taking into consideration age, sex, total cholesterol, high-density lipoproteins, smoking status, and systolic blood pressure (Wilson, D'Agostino, Levy, Belanger, Silbershatz, & Kannel, 1998). The Framingham Risk Score is to be used by physicians to calculate the risk of a heart attack among adults age twenty and older, who are free of heart disease and diabetes, in order to counsel these patients on life style modifications and target areas to reduce risk.

An additional, more comprehensive characterization that can aid in improving the health of an individual or population is a level of "cardiovascular health." Cardiovascular health, a basic term, now has a more composite denotation as defined by the American Heart Association (Roger et al., 2012). "Cardiovascular health" includes seven health factors or behaviors: smoking status, body mass index, physical activity, healthy diet components, total cholesterol, blood pressure, and fasting plasma glucose (table 19.2).

A person can be characterized as having poor, intermediate, or ideal "cardiovascular health" on each health behavior and health factor metrics. The ideal health behaviors are having a lean body mass, having a non-smoking status with low secondhand and thirdhand smoke exposures, participation in physical activity, and healthy nutritional practices that are consistent with a DASH (Dietary Approaches to Stop Hypertension) diet. The ideal health factors include having an untreated total cholesterol < 200 mg/dL, an untreated blood pressure < 120/ <80 mm Hg systolic and diastolic blood pressure, and a fasting blood glucose < 100 mg/dL (Rogers et al., 2012). According to the American Heart Association, "ideal cardiovascular health" is defined by the presence of optimal levels of all seven health

Table 19.2. The Levels of Cardiovascular Health in Adults Twenty Years or Older for the American Heart Association 2020 Impact Goals

	Levels of Cardiovascular Health		
	Poor	*Intermediate*	*Ideal*
Current Smoking	Yes	Former ≤ 12 months	Never or Former > 12 month
BMI	≥ 30 kg/m^2	25 –29.9 kg/m^2	< 25 kg/m^2
Physical Activity	None	1–149 min/wk Moderate 1–74 min/wk Vigorous	≥ 150 min/wk Moderate ≥ 75 min/wk Vigorous
Healthy Diet Components*	0 – 1	2 – 3	4 – 5
Total Cholesterol	≥ 240	200 – 239 or treatment	< 200
Blood Pressure	SBP ≥ 140 or DBP ≥ 90 mm Hg	SBP 120 – 139 DBP 80–90 mm Hg	< 120/ < 80 mm Hg
Fasting Plasma Glucose	≥ 126 mg/dL	100–125 mg/dL or treated to goal	< 100 mg/dL

* Health Diet Components include the count of meeting following day and weekly allowances: fruits and vegetables (4.5 cups/day), fish two 3.5-oz servings/week (preferably oily fish), whole grains (1.1 g fiber/10 grams of carbohydrates), three 1-oz equivalents/day, sodium ≤ 1500 mg/day, sugar-sweetened beverages ≤ 450 kcal/wk

Abbreviations: kilograms (kg), meters (m), minutes (min), week (wk), systolic blood pressure (SBP), diastolic blood pressure (DBP), millimeters of mercury (mmHg), milligrams (mg), deciliter (dL)

Adapted from American Heart Association Statistics Committee and Stroke Statistics Subcommittee, Roger et al., 2012

behaviors with the absence of CVD. The prevalence of individuals who meet this "ideal" classification is rare.

The number of "cardiovascular health" metrics (range 0–7) has been used to calculate hazards of cardiovascular disease incidence (Folsom, Yatsuya, Nettelton, Lutsey, Cushman, & Rosamond, 2011; Dong, Rundek, Wright, Anwar, Elkind, & Sacco, 2012). The presence of more ideal metrics have shown a statistically significant trend of increasing protective effects for CVD, including myocardial infarction, stroke, and vascular death (Dong et al., 2012; Folsom et al., 2011; Yang, Cogswell, Flanders, Hong, Zhang, Loustalot, Gillespie, Merritt, & Hu, 2012; Ford, Li, Zhao, Pearson, & Capewell, 2009; Shay, Ning, & Allen, 2012). Individuals in the Atherosclerosis Risk in Communities Study were shown to be 35 percent less likely to have CVD when they had one of the ideal metrics compared to those with zero, and this protective factor increased by the addition of ideal metrics present [hazard ratio (HR) = 0.65 (confidence interval (CI) = 0.55–0.77)] (Folsom et al., 2011). Individuals were 89 percent less likely to have CVD when having seven of the ideal metrics compared to those with none [HR = 0.11 (CI = 0.07–0.17)] (Folsom et al., 2011). The hazard for the cardiovascular health definition also allows the classification of children across the metrics. Data using the metrics in a young population provide support for the pursuit of that ideal cardiovascular health in childhood as an important strategy to prevent CVD in adulthood (Laitinen, Pahkala, Magnussen, Viikari, Oikonen, Taittonen, Mikkilä, Jokinen, Hutri-Kähönen, Laitinen, Kähönen, Lehtimäki, Raitakari, & Juonala, 2012).

In moving to achieve the goals of improving health and reducing behavioral and health risk factors, all segments of the population have to be considered. In urban environments, achieving these levels of health might be hampered by environmental and social barriers. Therefore, to only develop the matrix without determining strategies to develop settings that foster improved policies and environmental conditions, the metric becomes only a new way to look at the gaps and disparities in CVD rather than a tool to improve health.

Risk Factors and Etiology of CVD

CVD epidemiology has provided data to identify a number of accepted and known risk factors for CVD. The term *modifiable risk factor* is used to indicate conditions that are perceived within an individual's control to change, whereas nonmodifiable factors include those characteristics that cannot be changed and are determined at birth or conception. The "cardiovascular health" metric uses behavioral factors and health risk factors; some are modifiable, while others are not. Modifiable factors or characteristics are often behavioral or environmental. One could argue that some of the factors often considered modifiable are often not so easy to be modified. It does not make allowance for social, economic, and physical restrictions that coerce people into unhealthy behaviors.

Modifiable Risk Factors

The most common modifiable risk factors for cardiovascular disease include: smoking, lack of a proper nutritionally balanced diet, high salt intake, low potassium intake, lack of exercise, above moderate alcohol intake, and high stress. Poor diet and exercise patterns lead to being overweight, obesity, and an increased risk of type 2 diabetes.

Smoking. Smoking has been considered a major cause of CVD for over four decades. In the United States, smoking accounted for 33 percent of all deaths from CVD and 20 percent of deaths from ischemic heart disease in persons older than thirty-five years of age (Centers for Disease Control and Prevention, 2010). Surgeon General Reports have extensively reviewed the evidence suggesting smoking as a major cause of CVD in multiple reports dating back to 1971 (United States Department of Health, Education, and Welfare [USDHEW] 1971, 1979; United States Department of Health and Human Services [USDHHS] 1983, 2001, 2004). Beyond its status as an independent risk factor, smoking appears to have a multiplicative interaction with the other major risk factors for coronary heart disease—high serum levels of lipids, untreated hypertension, and diabetes mellitus (USDHHS, 1983). The general mechanisms by which smoking results in cardiovascular events include development of atherosclerotic changes, with narrowing of the vascular lumen and induction of a hypercoagulable state. The interaction of the physiological changes creates increased risk of acute thrombosis (USDHHS, 1983, 2004).

The 2010 report of the US Surgeon General concludes that there is a sharp increase in CVD risk with low levels of exposure to cigarette smoke, including secondhand smoke (Centers for Disease Control and Prevention (CDC), USDHHS, 2010). Smoking cessation is accepted to reduce the risk of cardiovascular morbidity and mortality for smokers with and without coronary heart disease. It should be a standard practice for all physicians to ask the smoking status of patients, and to encourage smoking patients to stop smoking and minimize smoke exposure.

Nutrition. Nutrition is another risk factor that has multiple components that impact health and clinical outcomes. In the area of nutrition, behaviors that promote poor health include the lack of a proper nutritionally balanced diet, which is deficient in the recommended daily allowance of vitamins and minerals (e.g., high in salt and sodium intake, low in potassium intake). Above moderate alcohol consumption can also be included in the nutrition category because it is a part of dietary habits.

Improper and poor nutritional habits include under consumption or over consumption of food types with a reduced energy expenditure, which leads to being overweight and obesity. Overweight is defined in adults as a body mass index (BMI) in the range of 25.0 to less than 30.0 kg/m^2 (Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion, 2012). In children, overweight is defined as a BMI between the eighty-fifth and ninety-fifth percentile by age (CDC, 2012). Obese is classified as a BMI greater than or equal to 30.0 kg/m^2 in adults. In children, the obese classification is for those with a BMI greater

than the ninety-fifth percentile by age. Overweight children and adolescents have an increased prevalence of traditional cardiovascular risk factors such as hypertension, hyperlipidemia, and diabetes, along with additional health conditions plus poor school performance (CDC, 2012). Data from the 2010 NHANES survey have shown overweight and obesity are associated with increased risk for CVD (Wilson, D'Agostino, Sullivan, Parise, & Kannel, 2002). Obesity was associated with significantly increased mortality caused by CVD, some cancers, diabetes, and kidney disease when evaluating data from NHANES (Flegal, Graubard, Williamson, & Gail, 2007). Specifically, abdominal obesity was an independent risk factor for ischemic stroke in all race/ethnic groups (Suk, Sacco, Boden-Albala, Cheun, Pittman, Elkind, & Paik, 2003; de Koning, Chiuve, Fung, Willett, Rimm, & Hu, 2011; Fung, Chiuve, McCullough, Rexrode, Logroscino, & Hu, 2008). The increasing prevalence of obesity is also driving the increased rates of Type-2 diabetes in children and adults (Fox, Pencina, Meigs, Vasan, Levitzky, & D'Agostino, 2006).

The DASH dietary patterns have been supported by the National Heart, Lung, and Blood Institute and the American Heart Association to provide basic guidelines to promote nutritional health (table 19.3).

The DASH diet has been evaluated in research studies and has been shown to promote healthy blood pressure and cholesterol levels. Long-term adherence has been associated with a decreased risk of heart failure, stroke, and several types of cancer (Blumenthal, Babyak, Hinderliter, Watkins, Craighead, Lin, Caccia, Johnson, Waugh, & Sherwood, 2010; Levitan, Wolk, & Mittleman, 2009; Fung et al., 2011). Unfortunately, there are environmental factors in the urban community that influence access to healthy food choices and limit individuals from being able to use nutrition as a primary disease prevention or proper weight management strategy. There exist a number of publications on food desserts in major urban cities that show environments where residents do not have access to fresh fruits, vegetables, and other healthy foods. What's the solution for nutrition, based on these socio-environmental factors?

Physical Inactivity. The Physical Activity Guidelines for Americans (2008) recommends that individuals engage in regular physical activity, defined as thirty

Table 19.3. Recommended Serving under Food Type with the Dietary Approaches to Stop Hypertension (DASH) Diet

	Number of Servings	
	1,600–3,100 Calorie Diet	*2,000 Calorie Diet*
Grains	6–12	7–8
Fruits	4–6	4–5
Vegetables	4–6	4–5
Dairy Foods (low to non-fat)	2–4	2–3
Lean meats, Fish, Poultry	1.5–2.5	2 or less
Nuts and legumes	3–6	4–5 per week
Fats and sweets	2–4	Limited

minutes a day, five times a week, for heart health. There are slight variations in the categorical guidelines given to support physical activity among children, adults, and older adults. Data report that among youth, girls are more inactive than boys (Carnethon, 2009). Data from the 2010 National Health Interview Survey (NHIS) indicated that only 47.2 percent of adults over the age of eighteen report regular moderate or vigorous physical activity (Schiller, Lucas, Ward, & Peregoy 2010). Physical activity was higher among men (52.1 percent) compared to women (42.6 percent), and among non-Hispanic Whites (51.4 percent) compared to non-Hispanic Blacks (37.3 percent) and Hispanics (36.3 percent) (Schiller et al., 2010). There is not a difference in physical activity recommendation for men versus women. The goals are the same, but more rigorous activity may be needed to increase heart rates to an optimal level for cardiac output. Multiple interventions have targeted and tailored activities for specific audiences, and more times than not more customized programs tailoring to personal interests are better received and adopted.

Physical inactivity is responsible for 12.2 percent of the global burden of myocardial infarction (MI) after accounting for other CVD risk factors such as cigarette smoking, diabetes, hypertension, abdominal obesity, elevated lipid profile, alcohol intake, and psychosocial factors (Carnethon 2009). On the basis of self-reported prevalence of inactivity (47.5 percent) and the prevalence of CVD (21.5 percent), the direct expenditures for CVD associated with inactivity were estimated to be $23.7 billion in 2001 (Oldridge, 2008).

The amount of physical activity a person has is critical to achieving optimal health, as well as improving further health risk after a diagnosis of hypertension, elevated lipids, or high cholesterol. However, there are elements of the environment that pose barriers to individuals increasing physical activity in a number of urban communities. Safety factors and availability of facilities and equipment impact choices to engage in physical activity (McConnell et al., 2010; Strath, Isaacs, & Greenwald, 2007).

Stress. Stress is a recognized and documented risk factor for CVD. Perceived stress arises from the interaction of certain objective social conditions, psychological characteristics, and personality traits (Larbarthe, 2011). Hemingway and Marmot characterize multilevel stress responses (i.e., physiological, cognitive, and behavioral) as mediators between social conditions that are conducive to stress and therefore the outcomes of CVD (Chandola, Brunner, & Marmot, 2006). Psychosocial factors can be defined as a measurement that potentially relates psychological phenomena to the social environment and pathophysiological changes (Hemingway & Marmot, 1999). A number of psychosocial factors have been investigated and found to have an association with CVD including depression, anxiety, aggression, type A-personality, hostility, racism, and long-term stress at work (Hemingway & Marmot, 1999). Fatal coronary heart disease, myocardial infarction, and angina pectoris have been shown to have an association with type A personality or hostility, depression, anxiety, and occupational stress (Oldridge, 2008). Hemingway and Marmot (1999), in a systematic review of psychosocial factors and coronary heart disease, characterize

psychosocial factors into four groups: "Psychological traits (type A behavior, hostility), psychological states (depression, anxiety), psychological interaction with the organization of work (job control-demands-support), and social networks and social support" (Hemingway and Marmot, 1999).

Study findings are often inconsistent; frequently the psychological factors are based on self-report and are more difficult to capture with standard definitions in mass populations. There have been arrays of diagnostic tools and scales used across studies that have made comparing study results or meta-analysis challenging when evaluating psychological characteristics associations with CVD. Over the last three decades the literature has grown and continues to support the linkage of psychosocial characteristics with CVD incidence and survival. Perhaps the attempts to independently measure the associations have failed because of the consistent effects of environmental and social influences. Urban environments are environments that are high in psychological stress. A number of the psychological factors are associated with other modifiable behaviors, such as eating habits, use of alcohol, physical activity, and smoking. When individuals are feeling high stress or depression, they are less likely to practice healthy behavior patterns.

Non-Modifiable CVD Risk Factors

Characteristics that are often considered non-modifiable risk factors for cardiovascular disease include age, sex, race, and family history. A study by Homko et al. compared inner city and rural residents in Pennsylvania controlling for some of the non-modifiable risk factors (Homko, Santamore, Zamora, Shirk, Gaughan, Cross, Kashem, Petersen, & Bove, 2008). Homoko et al. showed that based on blood pressure and cholesterol levels, smoking status, age, sex, and diabetes, urban dwellers had a greater risk of developing heart disease over the next ten years (18 percent) compared to rural residents (16 percent) (Homko, 2008).

Age. As with most chronic diseases, the risk of CVD increases with age (Labarthe, 2011). In CVD, the pathophysiological mechanisms that cause clinical disorders are superimposed on the heart and vessels that are modified by the aging process. Also as a person increases in age, their exposures to multiple risk factors, known and unknown, increase. The critical amount of exposure to start the disease process has a higher probability of occurrence as a person gets older and continues exposure over the years. The cells of the body show age by the decrease in cell replication. Comorbidities increase the risk of subsequent additional illnesses and new comorbidities. The ability for cells to detect and fight abnormal cells including infections decrease as one ages (Butenko, 1985). There are a number of older adults that are living in urban populations. The increase in the life expectancy in society has increased, and the baby boomer generation is growing older. Differences have been shown in life expectancy between rural and urban areas in England (Kyte & Well, 2010); life expectancy was lower in the urban areas. However, these trends do not exist independent of economic status in the United States (Bennett, Olatosi, & Probst, 2008).

Sex. Historically, men have been shown to have a higher incidence and mortality of CVD than women. This difference by sex has been consistently shown in multiple populations and in countries with low rates (Labarthe, 1998; McGovern, Jacobs, Shahar, Arnett, Folsom, Blackburn, & Leupker, 2001; Marmot & Elliot, 2009). There have been several hypotheses given to support this reason including: hormonal differences, body fat distribution and metabolic change differences, and variations in inflammation responses (Labarthe, 1998; McGovern, 2001; Marmot, 2009). However, the difference in prevalence and incidence of CVD between men and women has decreased, and the prevalence has become similar between men and women for multiple risk factors of CVD including elevated blood pressure, elevated low-density lipoprotein cholesterol, decreased high-density lipoprotein cholesterol, and cigarette smoking. Therefore, the question at hand is: Will the difference previously seen and documented continue to be present? If the difference between men and women continues in the future years, then more not fully understood genetic components are behind the differences in addition to environmental factors.

Race. It has not been demonstrated that there are genetic differences by race that makes one race independently more susceptible to CVD than another race. Often, there have been differences in incidence, prevalence, and mortality by race, which show African Americans having higher rates of CVD. When misinterpreted, the higher rates have been stated as being a result of a causal pathway of race. Simply stated, being of the African American or Hispanic race/ethnicity is often listed as a risk factor for CVD. However, just because higher rates are seen among certain race and ethnicity groups, an immediate causal link cannot be made between race and CVD. The argument by Richard Cooper in "A Note on the Biological Concept of Race and Its Application in Epidemiologic Research" (2002) is that human variation does not occur as a discrete variable. Has race been properly defined, or can it be defined by discrete categorical variables, has to be considered and questioned when reviewing the literature and observing differences highlighted by race. It can be maintained that the appearance of consistent patterns of mortality and prevalence differences by race should be only attributed to environmental and social factors (LaVeist, 2002).

Family History. Some individuals are predisposed to CVD due to their genetic risk factors and family history of CVD. It can be seen that the measurement of a few risk factors does not compare to the compressed information held in a simple family history for predictability of disease occurrence (Rao & Vogler, 1994; Kardia, Modell, & Peyser, 2003). History of a heart attack in both parents increases the risk of a person having a heart attack, especially when one parent has had a premature heart attack (Hemingway & Marmot, 1999). Sibling history of heart disease has been shown to increase the odds of heart disease in men and women by approximately 50 percent (Chow, Islam, Bautista, Rumboldt, Yusufali, Xie, Anand, Engert, Rangarajian, & Yusuf, 2011). The full genetic basis for CVD has not yet been determined, and genetic markers discovered thus far have not been shown to add to cardiovascular risk prediction tools beyond current models that incorporate

family history (Labarthe, 2011). A failure to consider environmental components of the disease, in addition to measurement of the susceptibility genotype, may lead to erroneous inferences concerning the role of genes in disease etiology. There are social constructs of the urban environment that should be considered in preventing CVD.

In considering urban poverty and cardiovascular disease health, the non-modifiable risk factors of CVD do not impact the pathology any differently in isolation, but age, sex, and race are an effect modifier of the environmental and social factors. Untraditional methods to determine effects and etiology of disease must continue to be explored and utilized to decrease disparities in CVD prevalence and mortality.

Non-Traditional Risk Factors: Social Determinants of Health

Socioeconomic status, changes in social conditions, environmental hazards, and community/neighborhood characteristics can all be considered differently than the other previously mentioned risk factors. As progress is made in the chapter, we would like to challenge the reader to explore the options of more nontraditional methods to determine causes and effects of disease. The pathology and etiology of cardiovascular disease is important and essential to fighting CVD incidence and mortality. However, there is an increased urgency and apparent need to utilize newer constructs, frameworks, and statistical modeling to account for individual variances, which result in the correlation of disease outcomes.

Social conditions of the population have been researched for decades in CVD epidemiology. Social epidemiology is a branch of the traditional public health science investigating the determinants and distribution of human disease that integrates sociology, anthropology, politics, and psychology in order to more comprehensively investigate "non-traditional" factors, or social determinants, that directly or indirectly influence health (Berkman & Kawachi, 2000). It also encourages more in-depth understanding of how and why some individual-level risk factors (e.g., obesity, smoking, physical inactivity) affect some populations in greater proportion by allowing social conditions that either facilitate or inhibit health-promoting practices to be examined as a correlate of health. Wilcox (2007) theorizes that social determinants of health assist researchers in understanding how factors considered to be "upstream" affect factors "downstream." More consideration has been given to the aspects of fetal and early postnatal development and their risks of CVD in adulthood.

The World Health Organization (WHO) created the Commission on Social Determinants of Health in 2005, and their goals reflected the mission of public health almost twenty years earlier by the Institute of Medicine Committee for the Study of the Future of Public Health (Institute of Medicine, 2000). The premise was that the conditions where people lived and worked could promote or prevent health depending on level of income, appropriate housing, safe workplaces, and access to health systems being determinants of health that lead to inequalities and therefore disparities.

EFFECTS OF URBAN POVERTY ON HEALTH

More and more literature is evolving to quantify that place, geographic location, and neighborhood matter and are determinants of health. Cities offer both the best and worst environments for health and quality of life. Positive and negative influences tend to cluster according to the specific community or neighborhoods within a city. A difference in neighborhood conditions can predict disease prevalence and life expectancy. The physical and social environments in urban contexts are formed by numerous multilevel factors. Global trends, national and local governments, civil society, financial markets, and the private sector collectively create the context in which local factors operate, all of which can support or challenge residents' health (Thomas & Quinn, 2008).

The increasing segregation of urban neighborhoods along lines of income is problematic for social and health issues. The downturn in the U.S. housing market and subsequent collapse of major financial institutions in 2007 affected the lives of countless urban residents. In many cities around the world, unemployment rose and social services, public entitlements, wages, and loan programs were cut (Thomas, 2008). However, before and after the changes in the economic problems of 2007, residential segregation represented a fundamental cause of racial disparities in poverty, education, and economic opportunity that perpetuate disparities in health (Williams, 2001). The social and geographic marginalization associated with segregation reinforces substandard housing, underfunded public schools, employment disadvantages, exposure to crime, environmental hazards, and loss of hope (Wilson, 1987).

The US Census Bureau (2010) recently reported that although the overall poverty rate was 15.1 percent, it was approximately two-thirds less for Whites (9.9 percent) and almost double for African Americans (27.4 percent). It has been reported that the gap between the wealthy and the poor in the United States has increased more than four-fold in the past twenty years, and the economic divide distinctly lies along racial lines (Shapiro, Meschede, & Sullivan, 2010). A prospective study that followed a cohort of families from 1984 to 2007 revealed the black-white gap in wealth increased from $20K to $95K during this time period (Shapiro, 2010); however, Domhoff (2011) estimated the wealth gap between average White and African American families to be 15-fold during 2007. If home equity is excluded from calculations to determine wealth, the income and wealth ratio by race escalates to 100:1 (Domhoff, 2011). Domhoff (2011) posits that while those with the top 20 percent of income control approximately 85 percent of the wealth in the United States, those at the bottom 40 percent of income hold a mere 0.3 percent of the wealth. Although the concentration of wealth distribution has a historical context that dates back to the nineteenth century (Domhoff, 2011), the wealthy have continued to gain more resources over time as the poor have retained less of what they had (Domhoff, 2011; Shapiro, 2010). These observed gaps in wealth may impact, either directly or indirectly, the social and

environmental factors observed in African American and White communities, which are known to have strong linkages to health outcomes.

Although socioeconomic status (SES) is a multidimensional construct, many of its elements are facilitated by their relationship to education and income. Education and income are commonly used markers to determine SES (Kennedy, Paeratakul, Ryan, & Bray, 2007). Individuals of higher SES are far more likely to experience positive health outcomes, while those of lower SES experience negative health outcomes. While SES may be substantially impacted by both income and education, these differences are not necessarily the result of their interaction (Kennedy et al., 2007). It is possible for individuals of lower educational attainment to have a high socioeconomic position, and vice versa. Nonetheless, researchers have found strong evidence correlating poor educational attainment with poor health outcomes (Banks et al., 2006; Conroy, Sandel, & Zuckerman, 2010). For example, prevalence rates were 14.3 percent for diabetes, 46.3 percent for hypertension, and 17.1 percent for heart disease among individuals with low years of schooling, compared with 9.5 percent, 37.0 percent, and 12.0 percent among individuals with high years of schooling, respectively. Conroy, Sandel, and Zuckerman (2010) maintain that despite this evidence, the determination of educational outcomes or achievements based on other social determinants of health is quite challenging. Yet other researchers argue the contrary (Do & Finch, 2008; Iton, 2005; Jargowsky, 1997; Jones-Jack, Jack, Jones & Scribner, 2010; Schulz, House, Israel, Mentz, Dvonch, Miranda, & Kannan, 2008). Jargowsky (1997) specifically addressed this issue by describing not only the difference in educational attainment by poverty level based on U.S. Census data but also suggested that the data underestimate the true differences in education across neighborhoods of varying SES.

Researchers have determined that an environment of life long poverty or socioeconomic disadvantage strongly impacts health status in adulthood (Conroy et al., 2010; Forsdahl, 1977; James et al., 2006; Kauhanen, Lakka, Lynch, & Kauhanen, 2006; Wamala, Lynch, & Kaplan, 2001). Wamala et al. (2001) measured a significantly increased risk of CHD among women who were exposed to socioeconomic disadvantage during early and later life (odds ratio = 2.48 and 3.22, respectively) after adjusting for traditional CHD risk factors and martial status. However, life long (early and later life combined) socioeconomic disadvantage increased CHD risk by 4.2-fold compared to women who had not experienced any socioeconomic disadvantage (Wamala, 2001). Simiarly, other researchers indicated a 1.32-fold increased risk of CVD mortality among men who experience socioeconomic disadvantage during childhood, which remained after adjusting for behavioral risk factors and socioeconomic position in adulthood (Kauhanen et al., 2006).

The differences in CVD by sex previously mentioned, where women previously developed coronary heart disease later in life, is threatened by the increasing prevalence of risk factors. There is also an increase in the psychosocial exposures women are enduring. Urban poverty has become highly feminized. Globally, poor urban women tend to have lower-paying jobs and higher illiteracy rates. This necessitates

that women are then excluded from certain types of jobs because of lack of education or discriminatory practices.

Multiple studies have shown that poor health is partly a function of macro-level socioeconomic disadvantage (House, 1974; Hemingway and Marmot, 1999). There are factors that inhibit primary prevention and improvements in health in a poor urban community that the literature supports. Low income denies access to nutrition, quality care, physical activity, treatment, and medical procedures.

Lack of Resources in Urban Communities

Individuals with a lack of financial resources are at higher risk for exposure to environmental toxins, including lead, passive smoke, air pollution, cockroach excrement, violent crime, alcohol stores, and cigarette and smoking advertisements (Bernard & McGeehin, 2003; Mannino, Caraballo, Benowitz, & Repace, 2001; Gunier, Hertz, Von Behren, & Reynolds, 2003; Leaderer, Belanger, Triche, Holford, Gold, Kim, Jankun, Ren, McSharry, Platts-Mills, Chapman, & Bracken, 2002; Morland, Wing, Diez, & Poole, 2002; Laws, Whitman, Bowser, & Krech, 2002). These are exposures that can occur from birth to adulthood in poor urban environments. Some of these exposures can lead to risky behaviors that further perpetuate negative health outcomes.

Crime and violence are typically more severe in urban compared to rural areas (Weisheit, Falcone, & Wells, 1994). Individuals who experience exposure to neighborhood factors such as this often have high levels of stress. It has been suggested that as a consequence of repeated exposure to stress and psychological trauma, children in urban populations of low socioeconomic status can display a cardiovascular response sensitivity to psychological stress (Chen & Matthews, 2001; Alim, Graves, Freedy, Aigbogun, Lawson, & Mellman, 2006; Gillespie, Bradley, Mercer, Smith, Conneely, Gapen. Weiss, Schwartz, Cubells, & Ressler, 2009).

Low income is associated with reduced access to health care and lack of insurance (Shi, 2001). Low income has also been shown to be associated with lack of quality in care available and preventative health services available. Hospital outpatient/urgent care clinics, community health centers, and other not-for-profit organizations are often providers of health care to the poor but are constantly in budget constraints and the target of budget cuts (Institute of Medicine, 2000). These clinics often have large numbers of patients they are trying to service with low staff and clinic resources. Furthermore, a number of patients in the low-income urban clinics often have multiple co-morbidities. Co-morbid illnesses necessitate the need for more patient-doctor time, medication, and treatment. More patient time in overcrowded clinics have cascading effects of longer appointment times, more wait time in the waiting room, patients unable to stay away from work to be seen in the clinic, missed appointments, and then overbooking appointments, which maintains a cycle of undiagnosed and untreated urban patient populations. Physicians serving urban

populations also face additional challenges around appropriate and adequate communication of cultural or health literacy needs (Carrillo, 1999).

Conclusion

A number of risk factors for cardiovascular disease are known, including biological and environmental factors. Strategies to prevent and overcome these risk factors in areas of urban poverty are not as well understood. Looking at CVD and the impact of the urban environment takes into consideration a cities' geography and climate; housing conditions; access to safe water and sanitation; transportation; and air quality. Poor urban environments provide more of an opportunity for negative impacts. Public policies largely determine the distribution of the social determinants of health and contribute to health and health inequities (Chircop, 2011). Therefore, to have greater public health impact in reducing the prevalence of chronic diseases and CVD, more systemic changes should be supported.

Environmental, social, and cultural supports for change have to be adopted for sustained behavior changes to occur that improve the health of the mass population without differential advantages given to segments of the population. There are limitations to awareness, access, and sustained behavior change on an individual level. Support for change at multiple levels has to be presented for sustained change to occur. The lack of ability to modify what are often classified as modifiable risk factors must be acknowledged when working with urban community health care providers. Time and resources have to be spent to address the risk factors in that community. When health care providers better address all of the components that influence people's appraisal of their cardiac health and appropriate primary and secondary interventions, decision making related to positive health outcomes are more likely to follow (WHO, United Nations, Habitat for Humanities, 2010).

Geoffrey Rose, in his book entitled *The Strategy of Preventive Medicine* (1992), states: "The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social." This was stated twenty years ago, and continues to be supported considering the current prevalence and disparities of chronic diseases. The importance of the environment (i.e., neighborhood, town, or city) is emphasized in preventing cardiovascular and chronic diseases. Prevention can work on an individual basis but can be substantially more effective and sustainable on a community or macro level. Prevention at the community level requires the community to be engaged, empowered, and invested in its overall success; without community ownership, there is little accountability or effort to monitor strategies that both promote or inhibit health improvements.

Future Directions

CVD continues to be the leading cause of death worldwide, and it places a massive socioeconomic burden on individuals and societies, particularity in low- and

middle-income countries (Smith, 2012). Informed action by governments and other stakeholders have been shown to dramatically reduce CVD risk (Smith, 2012). Children are a major concern and target group for interventions. Interventions should encompass programmatic, systematic, and policy change to tackle CVD prevention in urban environments.

To achieve improvements in cardiovascular health, the American Heart Association (Smith, 2012) published an update to achieve the 2020 goals in heart health. As such, all segments of the population will need to focus on improved cardiovascular health behaviors, in particular with regard to diet and weight, as well as increased physical activity and further reduction of the prevalence of smoking (Roger, 2012). More children, adolescents, and young adults will need to learn how to preserve their ideal levels of cardiovascular health factors and health behaviors into older ages.

It is imperative that policymakers continue to increase an understanding of public health implications of laws and policy. Policies and strategies that allow individuals to adopt healthy behaviors and avoid unhealthy ones are crucial to successful urbanization (Smith, 2012). Efforts also have to be coordinated across community organizations and service entities to maximize efforts. Interventions should offer alternatives that are doable within environmental restrictions, whether urban or rural. As cities increase in size, it is vital that infrastructures are developed to facilitate not only heart-healthy behavior but also healthy lifestyle behaviors in general.

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20

Coming to America

Mental Health Needs Among Undocumented Mexican Immigrants

Elián P. Cabrera-Nguyen and Vetta L. Sanders Thompson

Mexican immigrants belong to the largest and one of the fastest-growing minority groups in the US, and they account for over one-third of the nation's foreign-born population. Census data show that 27 percent (n = 12.7 million) of all self-identified Latino/as (N = 46.9 million) in the US are Mexican immigrants (Pew Hispanic Center [PHC], 2009; United States [US] Census Bureau, 2009; US Census Bureau, 2010). The size of the Mexican immigrant population likely exceeds U.S. Census Bureau figures due to the presence of undocumented Mexican immigrants (UMIs). Fearing detection and deportation, UMIs generally avoid participating in the census and are undercounted more than any other difficult-to-enumerate group (Massey & Capoferro, 2004). Some demographers estimate there are roughly seven million UMIs in the US and that 60 percent of all Mexican immigrants are undocumented (Massey, 2010; PHC, 2009). UMIs therefore comprise a sizable portion of the U.S. population. Although Latinos have a large rural presence, the population is largely concentrated in established urban areas (Motel & Patten, 2012). Almost half of the population lives in ten metropolitan areas. Due to an overrepresentation in the construction industry and hospitality sector (eating, drinking and lodging), foreign-born Latinos saw a significant rise in unemployment during the great recession, but employment in this industry has rebounded along with jobs in professional business services, retail trade and manufacturing (Kochkar, 2012).

Mental illness has been identified as a national public health concern in the US (United States Department of Health and Human Services, 1999; United States Department of Health and Human Services, 2001; World Health Organization, 2008). Psychiatric disorders are among the most debilitating conditions in the US, and they exact an even greater toll on minorities (Buka, 2008; United States Department of Health and Human Services, 2001; World Health Organization, 2008). Despite

comprising a large sector of the U.S. population, there is a dearth of research on UMI mental health (Sullivan & Rehm, 2005).

Despite the stressors associated with immigration and greater poverty, less "Americanized" Latino/a immigrants have been found to have better health and mental health in comparison to US-born Latino/as and non-Latino/a whites across a range of indicators. This phenomenon has been referred to by various labels including the epidemiological paradox, the immigrant paradox, the healthy immigrant effect, and the Hispanic paradox (Alegría et al., 2008; Flores & Brotanek, 2005; Franzini, Ribble, & Keddie, 2001). However, recent psychiatric epidemiological studies that disaggregated Latino/as by ethnic/national origin group—Cubans, Puerto Ricans, and Mexicans—only consistently found the immigrant paradox for Mexican-origin adults (Alegría et al., 2008; Alegría, Canino, Stinson, & Grant, 2006).

The finding that the immigrant paradox applies consistently to Mexican immigrants but not Cubans or Puerto Ricans is important to our ability to appropriately direct mental health resources to immigrant communities. However, researchers have been unable to examine the mental health of Mexican immigrants by documentation status in existing national psychiatric epidemiology studies and the finding that the Latino/a immigrant paradox applies mainly to Mexican immigrants may be artifactual (the result of sampling or methodological features of studies). Fearing detection and deportation, UMIs generally avoid participating in the census and are undercounted more than any other difficult-to-enumerate group (Cornelius, 1982; Massey & Capoferro, 2004). Since UMIs are likely underrepresented in national probability samples (Cornelius, 1982; Massey & Capoferro, 2004), this factor may be especially salient. UMIs confront social attitudes and governmental policies which may contribute to certain experiences and socio-demographic differences that, in turn, may lead to differential exposure to risk factors for poor mental health. First, UMIs tend to avoid participating in academic research studies for the same reasons they avoid participating in the census: fear of detection and deportation (Cornelius, 1982; Massey & Capoferro, 2004; Massey & Riosmena, 2010). Most national psychiatric epidemiologic surveys have used sampling procedures which may have resulted in a systematic under sampling of the largest sector of the U.S. Mexican immigrant population. Consequently, those Mexican immigrants with the highest risk for psychiatric disease are likely to be severely underrepresented in studies and epidemiological samples that currently exist.

The purpose of this chapter is to review what is known about Mexican immigrant mental health, particularly as it relates to UMIs. We begin by clarifying the terminology used and proceed to a review of what is known about reasons for Mexican immigration and mental health among Mexican immigrants. The chapter ends with what is known about UMI mental health and provides the logic for why Mexican UMI mental health may not conform to the immigrant paradox.

Terminology

The distinction between "immigrants" and "migrants" is often unclear. While both terms can refer to foreign-born persons living in the US, researchers have used these terms in different ways. For example, some researchers consider settlement patterns as the distinguishing characteristic. According to this definition, "immigrants" are foreign-born persons who intend to settle permanently in the US, whereas "migrants" intend to return to their countries-of-origin (Ellis & Wright, 1998; Passel, 2005). Other researchers would add that "migrant" also implies engaging in certain types of labor, such as seasonal agricultural work and construction (Piacenti, 2010). In addition, one study defined "immigrant" as any foreign-born person living in the US regardless of documentation status, and "migrant" as a foreign-born person with government authorization to live temporarily in the US and engage in seasonal employment (López, 2001). We will use the terms "immigrant" and "migrant" interchangeably to refer to foreign-born persons living in the US with two caveats. First, when referring to a study that uses one term and supplies a particular definition for it, we will note how the term is defined and use it accordingly as necessary. Second, when referring to island-born Puerto Ricans living in the mainland US, we will only use the term "migrant." Puerto Rico is a US colony, and its inhabitants are US citizens according to US law and are therefore not immigrants.

Immigrants in the US are often discussed from either a juridical perspective or a non-juridical perspective. Juridical discourse uses terms like "legal status" to describe whether or not an immigrant has received the US government's permission to reside within its claimed borders. This perspective views immigrants living in the US without government sanction as violating US law and therefore as criminals who deserve punishment (Johnson, 1996). Non-juridical discourse uses terms like "documentation status" to describe (a) whether or not an immigrant entered US territory in accordance with US norms; (b) whether or not an immigrant's residence in the US has been recorded by government officials; and (c) whether or not the immigrant possesses residence papers mandated by US law (Paspalanova, 2008).

These perspectives have resulted in a number of terms to describe immigrants who live within the borders claimed by the US government without its sanction. Commonly used terms include "illegal aliens," "illegal immigrants," "unauthorized immigrants," and "undocumented immigrants" (De Genova, 2002; Paspalanova, 2008). First, the use of "alien" to refer to non-citizens has been criticized for being dehumanizing and promoting the "othering" of immigrants. It has also been criticized as a pejorative code word for referring to immigrants of color and as a way of cloaking racism under the guise of a respect for the law (Johnson, 1996; S. McGuire & Canales, 2010). Next, using "illegal" as an adjective to modify "immigrant" is problematic because (a) it is conceptually inaccurate; only acts are governed by the penal code and an "immigrant" is a person, not an act; (b) the term "illegal" has negative social and political emotive connotations that politicians and the media have exploited to manipulate public sentiment about the issue of immigration and to

scapegoat immigrants (Paspalanova, 2008). Finally, although the terms "unauthorized" and "undocumented" are sometimes used interchangeably to modify "immigrants," some researchers recommend "undocumented immigrant" as the preferred terminology because it is considered conceptually accurate and emotionally neutral (De Genova, 2002; S. McGuire & Canales, 2010; Paspalanova, 2008). In this chapter, we will use non-juridical terminology. We refer to an immigrant's "documentation status" and not his or her "legal status" unless citing a source that explicitly uses the term "legal status." The term "undocumented immigrant" is used instead of the alternatives. The decision to use "undocumented immigrant" instead of "unauthorized immigrant" is based on the aforementioned recommendations in the literature. The adjective "unauthorized" is used to modify behaviors defined as such by US law (e.g., "unauthorized border-crossing") and not to modify people.

This chapter uses "psychiatric disorders" and "mental disorders" to refer to diagnosable health conditions that involve changes in mood, thinking, or behavior associated with significant distress and/or impairment in functioning. "Mental illness" is used to refer collectively to all mental disorders. The term "mental health problems" is used to refer to psychiatric signs and symptoms that do not meet the criteria for a diagnosable mental disorder. These definitions are consistent with how the terms are defined in the Surgeon General's most recent report on mental health (United States Department of Health and Human Services, 1999).

THEORIES OF MEXICAN MIGRATION TO THE UNITED STATES

Four theories are predominant in the literature on Mexican migration to the United States. These theories include the neoclassical economic theory of migration, the new economic theory of labor migration, the theory of cumulative causation, and the theory of economic integration (Cornelius & Rosenblum, 2005; Massey, Durand, & Malone, 2003; Massey & Riosmena, 2010). These theories are not mutually exclusive, and their relative explanatory value may vary across individual migrants and specific historical time points (Cornelius & Rosenblum, 2005; Massey & Riosmena, 2010).

Neoclassical Economic Theory of Migration

Neoclassical economic theory views Mexican migrants as individual rational actors seeking to maximize lifetime income. This theory posits that the decision to make an authorized or unauthorized border crossing is based on a simple cost-benefit analysis (Cornelius & Rosenblum, 2005; Massey et al., 2003; Massey & Riosmena, 2010). The benefit is presumed to be financial—mean wages in the US are five times greater than mean wages in Mexico (Massey & Riosmena, 2010). Costs may include (a) the material costs of traveling to and resettling in the US, (b) the psychological costs of

separation from family and friends, and in the case of UMIs, (c) the physical and psychic costs of an unauthorized border crossing (Cornelius & Rosenblum, 2005; Massey et al., 2003). This theory predicts that a rational actor will choose unauthorized migration if the perceived benefit outweighs the perceived costs (Massey & Riosmena, 2010).

US border control policies have been (and continue to be) guided by the neoclassical economic theory of migration despite studies showing it does not fully explain unauthorized Mexican migration to the US (Cornelius & Rosenblum, 2005; Massey et al., 2003; Massey & Riosmena, 2010). These policies aim to deter unauthorized Mexican migration by making the financial, physical and psychological costs of an unauthorized border crossing outweigh its benefits (Massey & Riosmena, 2010). Consequently, US border control policy has focused largely on achieving this aim by intentionally making an unauthorized crossing more lethal via militarization of the US-Mexico border (Dunn, 2001; Vargas, 2001).

Enhanced border militarization has had the opposite effect of what the neoclassical economic theory of migration would predict. Raising the financial, physical and psychological costs of an unauthorized border crossing paradoxically increases the likelihood that prospective migrants will attempt (or re-attempt) an unauthorized border crossing (Cornelius & Salehyan, 2007; Massey & Riosmena, 2010). Moreover, prospective migrants are aware of the increased costs of an unauthorized border crossing, such as a greater risk of injury or death, yet they remain undeterred (Cornelius & Salehyan, 2007; DeLuca, McEwen, & Keim, 2010; Massey & Riosmena, 2010). As one Mexican migrant noted, "We have no other option. . . . Our only solution is to work in the United States to be able to help the family" (DeLuca et al., 2010, p. 120). Consequently, factors beyond the individual-level cost-benefit analyses proposed by neoclassical economic theory of migration may be involved.

New Economic Theory of Labor Migration

The new economic theory of labor migration (NETLM) offers an explanation for why efforts to increase the costs of unauthorized migration have been unsuccessful. The NETLM differs from the neoclassical economic theory of migration in several ways. First, families and households serve as the unit of analysis in NETLM (Cornelius & Rosenblum, 2005). Second, NETLM posits that authorized and/or unauthorized migration is part of a collective effort to cope with a failed local market by sending one or more household members to work in the US. Third, the NETLM maintains that unauthorized migration is intended to be temporary, with the goal being to resolve economic threats to the family's ability to sustain the household in Mexico—not to maximize individual lifetime earnings (Massey et al., 2003; Massey & Riosmena, 2010). If unauthorized migration is a temporary collective strategy to ensure a household's well-being in Mexico, then efforts to increase the costs of an unauthorized border crossing may fail because UMIs' decision to migrate is the outcome of a collective process and not just a self-interested, individual cost-benefit

calculation. The NETLM further suggests that increased border militarization disrupts UMIs preference for circular migration and provides an incentive for more permanent settlement in the US, which may explain why the population of UMIs has more than doubled since the onset of border militarization (Cornelius, 2005; Massey & Riosmena, 2010).

Cumulative Causation Theory

Current scholarship has proposed cumulative causation theory to help explain the failure of border control policies guided by neoclassical economic theory (Massey & Espinosa, 1997; Massey & Riosmena, 2010). Cumulative causation theory holds that each Mexican migrant who successfully engages in an unauthorized border crossing causes an increase in the social capital available to prospective UMIs. Social capital in this case includes social networks that serve as potential sources of material support, information, and social support. The cause of undocumented migration becomes cumulative because each migrant who makes a successful unauthorized border crossing also makes social capital in the US available to his or her particular network of friends, family and community members (Massey & Riosmena, 2010).

According to cumulative causation theory, unauthorized migration becomes a self-perpetuating process as social capital for UMIs increases with the success of each unauthorized border-crossing (Massey & Riosmena, 2010). Access to existing social networks may lower a prospective UMIs' perception of the risks associated with an unauthorized border-crossing. US efforts to raise the cost of unauthorized migration by increasing border militarization may have been counterbalanced by prospective UMIs' perceived access to existing social capital (Massey & Riosmena, 2010). In addition, cumulative causation theory also maintains that unauthorized migration is self-perpetuating because it creates a culture of migration in some Mexican communities over time. This so-called culture of migration refers to a set of ostensibly culturally transmitted values that encourage undocumented migration because of perceived benefits to the family and community. Unauthorized migration becomes normative and even expected of young adults—those who do not migrate are stigmatized as being lazy (Kandel & Massey, 2002).

Theory of Economic Integration

The final theory under consideration, economic integration, or world systems theory, describes a line of thought that views authorized and unauthorized Mexican migration from a structural perspective (Cornelius & Rosenblum, 2005; Massey et al., 2003). Central to this theory are the concepts of economic globalization and neoliberalism. Economic globalization refers to the increasing integration of international financial markets, and it often unfolds as corporations from wealthy nations insert capitalist "free market" systems into non-capitalist and poor nations—these

nations are sometimes described as "pre-market" or "undeveloped" (Cornelius & Rosenblum, 2005; Massey et al., 2003; Massey & Sánchez, 2009). As discussed by McGuire and Martin (2007), the neoliberal model is "a market oriented policy that maintains and perpetuates the power and hegemony of the global corporations that are its chief architects . . . [It] opposes governmental regulations or any external controls for accountability to communities and seeks to privatize both goods and services for the sole purpose of economic profitability" (p. 17). Scholars argue that the neoliberal model involves rolling back social welfare benefits to insure a surplus of low-wage workers (Cleaveland, 2011) while imposing a set of structural adjustments on poor and/or non-capitalist countries by corporations under the auspices of the World Bank and International Monetary Fund with the stated goal of promoting economic growth. These structural adjustments include lowering tariffs, eliminating quotas, removing laws that restrict foreign ownership and investment, drastically reducing the government, and an emphasis on the privatization of the public sector (Massey & Sánchez, 2009; S. McGuire & Georges, 2003).

In the case of Mexico, the neoliberal model was enacted via the formal agreement known as the North American Free Trade Agreement (NAFTA) of 1994. In accordance with the neoliberal model, NAFTA removed restrictions on the movement of capital but not labor, thereby further enriching Mexico's wealthy elite while having a "devastating" (S. McGuire & Georges, 2003, p. 187) and "wrenching" (Massey & Sánchez, 2009, p. 8) effect on most Mexicans. Applied to Mexico, the neoliberal model exacerbated unemployment, increased poverty and caused a decline in wages (Massey & Sánchez, 2009; S. McGuire & Georges, 2003).The flood of US business investments to "develop" industry in Mexico following the passage of NAFTA was directly linked to the displacement of fifteen million small farmers and rural people and the onset of massive undocumented Mexican migration to the US (Massey & Sánchez, 2009; S. McGuire & Georges, 2003). From an economic integration or world systems theory perspective, UMIs are compelled to migrate by exogenous economic forces which blur the line between refugees, who are *involuntarily* forced from their homes, and *voluntary* migrants, who *choose* to migrate for economic or family reasons (Boehm, 2011; Cornelius & Rosenblum, 2005; Massey et al., 2003; S. McGuire & Georges, 2003).

This brief review has highlighted the major theories used to explain some of the numerous factors that may contribute to a prospective Mexican migrant's decision to engage in an unauthorized border-crossing. Some of these factors may have the potential to be psychologically salubrious, such as the possibility of supporting one's family and the benefits associated with employment. However, it is also clear from this review that there are factors that could reasonably be expected to have a deleterious impact on UMI mental health, most notably related to experiences crossing the border. The next section provides a brief overview of existing psychiatric epidemiological research on Mexican immigrants, followed by a review of what is currently known about the association between an undocumented status and mental health.

PSYCHIATRIC EPIDEMIOLOGY OF MEXICAN-ORIGIN ADULTS IN THE UNITED STATES

Community, regional and national psychiatric epidemiologic surveys have found evidence for the immigrant paradox among Mexican-origin adults in the United States. These surveys include the Los Angeles Epidemiologic Catchment Area Study (LA-ECAS) (Robins & Reiger, 1991), the Mexican American Prevalence and Services Survey (MAPSS) (Vega et al., 1998), the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) (B. Grant, Kaplan, Shepard, & Moore, 2003), and the National Latino and Asian American Study (NLAAS) (Alegría et al., 2004). Despite different methodological strengths and weaknesses, the immigrant paradox was consistently found among Mexican participants across surveys (see table 20.1). Indeed, psychiatric epidemiologic studies that disaggregate Cubans, Puerto Ricans and Mexicans instead of lumping them together for analysis have found that the Latino paradox may more aptly be dubbed the "Mexican paradox" because it has only consistently been found for Mexicans (Alegría et al., 2008; Alegría et al., 2006). None of these studies have examined documentation status as a possible site of intragroup differences in psychiatric disorder prevalence rates among Mexican-origin adults in the United States.

Two other national psychiatric epidemiology surveys, the National Comorbidity Survey (NCS) (R. Kessler et al., 1994) and the National Comorbidity Survey-Replication (NCS-R) (R. C. Kessler & Merikangas, 2004) contain data on prevalence rates of psychiatric disorders among Mexican-origin adults by nativity status. However, both surveys were administered exclusively in English. Findings specific to analyses of these two data sets are therefore not presented because this methodological limitation likely resulted in a systematic sampling error that (a) excluded more recently arrived Mexican immigrants, and (b) excluded less Americanized Mexican immigrants. Consequently, these surveys may yield biased parameter estimates that inaccurately inflate mental disorder prevalence rates among Mexican immigrants (Breslau et al., 2007; J. I. Escobar, Nervi, & Gara, 2000).

The LA-ECAS was the first psychiatric epidemiological survey to identify an "immigrant paradox" in the prevalence rates of psychiatric disorders among Mexican-origin individuals in the United States. The LA-ECAS employed a two-stage area probability sampling design and was administered to 3,132 adults in Los Angeles, California, roughly half of whom were of Mexican origin. Researchers administered the Diagnostic Interview Schedule (DIS) to obtain DSM-III diagnoses. The DIS was administered in either English or Spanish depending upon the participant's preference. The Spanish DIS has demonstrated good test-retest reliability among monolingual Spanish speakers and fair-to-good test-retest reliability when compared to the English version of the DIS among bilingual respondents (Burnam, Hough, Karno, & Escobar, 1987; J. I. Escobar & Vega, 2000; Robins & Reiger, 1991). A major limitation of the LA-ECAS is that its findings cannot be generalized to Mexican-origin adults outside of the Los Angeles area.

The MAPSS is a regional survey of psychiatric disorders among Mexican-origin adults in Fresno County, California. Using a fully probabilistic stratified multistage cluster sampling design, Vega and colleagues (1998) obtained 3,012 participants from rural and urban areas in Fresno County. The researchers used a modified version of the Composite International Diagnostic Interview (CIDI) to assess for DSM-III-R psychiatric disorders and gave participants the option to be interviewed in Spanish or English. Findings from the MAPSS also support the presence of an immigrant paradox among Mexican-origin adults. Notably, Vega and colleagues cited participants' concern about documentation status as a possible methodological limitation that may have resulted in underreporting of symptoms and misrepresentation of birthplace. Another possible limitation is that the MAPSS sample was drawn entirely from Fresno County in California, a community with a large number of Latino residents. Just over 38 percent of the population is Latino, and almost all of these Latinos are of Mexican origin (Vega et al., 1998). Mexican immigrants residing in this community are therefore privy to a source of social support from a co-ethnic community, a resource that is not necessarily available to Mexican immigrants residing in other regions of the country. These factors preclude generalizing findings from the MAPSS to the entire US population of Mexican-origin adults.

The NESARC used a multistage probability sampling design to obtain a nationally representative sample of US adults ages eighteen and up (N = 43,093), and 4,558 were Mexican-origin adults. DSM-IV psychiatric disorders were assessed using the Alcohol Use Disorder and Associated Disabilities Interview Schedule-DSM-IV Version (AUDADIS-IV), a fully structured diagnostic interview with established psychometric properties for use with Latino populations. The interview was conducted in English or Spanish based on participant preference. Psychiatric disorder prevalence rates by nativity status among the Mexican participants in the NESARC also support the notion of an immigrant paradox. Grant and colleagues (2004) identified two potential limitations to the NESARC: (1) response bias due to intragroup differences in race/ethnicity and immigration status, and (2) differences in response tendencies among English-speaking Mexican American participants (e.g., acquiescence, trait desirability, and social approval).

The NLAAS is the first nationally representative psychiatric epidemiological study of English-speaking and Spanish-speaking Latinos (N = 2,554) in the United States (Alegría et al., 2007). The NLAAS used a multistage stratified probability sampling design of Latino adults eighteen years and older in the coterminous United States. Institutionalized persons and people living on military bases were excluded from the sample. The Mexican sample consists of US-born Mexican Americans (n = 380) and Mexican immigrants (n = 488). The CIDI was used to assess for DSM-IV psychiatric disorders. Participants were interviewed in either Spanish or English depending on the language in which they were most proficient. Bilingual participants had the choice to be interviewed in either language. Analysis of psychiatric disorder prevalence rates among the various Latino ethnic groups in the NLAAS only consistently found the immigrant paradox among the Mexican-origin adults in the Latino sample (Alegría et al., 2008).

Table 20.1. The Latino Paradox in Psychiatric Epidemiological Surveys

		Lifetime Prevalence Rates (percentage)	
Study	*Disorder/Diagnostic Composites*	*US-born*	*Mexico-born*
LA-ECAS[1]	Major depression	6.9	3.3
	Dysthymia	6.5	3.2
	Panic	1.0	1.0
	Phobia	16.8	10.1
	Obsessive compulsive disorder	2.0	1.5
	Alcohol abuse/dependence	24.4	14.4
	Drug abuse/dependence	8.4	1.6
MAPSS [2]	Any affective disorder	18.7	8.0
	Any anxiety disorder+	23.2	13.0
	Any substance abuse/dependence	27.7	10.5
	Any disorder	48.1	24.9
NESARC[3]	Any mood disorder	19.3	10.2
	Any anxiety disorder	16.3	9.1
	Any drug use disorder	12.0	1.7
	Any alcohol use disorder	30.5	15.3
	Any disorder	47.6	28.5
NLAAS[4]	Any depressive disorder	20.4	12.9
	Any anxiety disorder	20.0	14.2
	Any substance disorder	21.4	7.0
	Any disorder	39.2	23.9

[1]Analyses from Burnam et al., 1987; Only disorders with prevalence rates > 1 per 100 were reported; [2]Analyses from Vega et al., 1998; [3]Analyses from Grant et al., 2004; [4]Analyses from Alegría et al., 2008; +Does not include generalized anxiety disorder.

All of these studies share one potentially important methodological limitation. They may have committed the "category fallacy" by attempting to apply concepts and instruments developed in a Western context to individuals from a different culture (J. I. Escobar & Vega, 2000). By using instruments that impose Western psychiatric nosology on other cultures for whom aspects of the nosological system may not be meaningful, researchers may have introduced a methodological artifact that threatened the studies' validity (Alegría, Vila et al., 2004). The NLAAS is unique among these psychiatric epidemiological surveys in the lengths to which the researchers went to mitigate this potential methodological limitation. Interested readers are referred to Alegría and colleagues (2004) for details.

UNDOCUMENTED STATUS AND MENTAL HEALTH

The paucity of quantitative studies that examine UMI mental health is understandable given that UMIs are a hard-to-reach hidden population, and researchers are forced to use suboptimal sampling techniques (Cornelius, 1982; Massey & Capo-

ferro, 2004; Sullivan & Rehm, 2005). While the few relevant quantitative studies have methodological limitations such as questionable generalizability, their findings collectively suggest that UMIs may have worse mental health compared to their documented counterparts.

Rodriguez and DeWolfe (1990) conducted the earliest study of the relationship between documentation status and mental health among Mexican immigrants. The aim of the study was to assess Mexican immigrants' mental health following the passage of the Immigration Reform and Control Act of 1986 (IRCA).[1] The researchers obtained a convenience sample of ninety Mexican immigrant women from a community family practice medical clinic. Women were excluded if (a) they presented with current psychiatric symptoms as a primary or secondary condition, or (b) they had presented at the clinic with psychiatric symptoms for any reason in the preceding two years. The participants were then divided into three equal groups: (a) UMI women who reported that they were qualified to apply for legal residence under IRCA, (b) documented immigrants who had lived in Mexico at least up to age twelve, and (c) UMI women who reported that they did not qualify to apply for legal residence under IRCA. Next, the researchers examined levels of social support for each group and then combined the documented immigrants and the UMI women qualified to apply for legal residence into one group.[2] UMI women who did not qualify to apply for legal residence had significantly higher mean depression and hostility scores on the Symptom Checklist-90-Revised (SCL-90-R, Derogatis, 1985; as cited in R. Rodriguez & DeWolfe, 1990) compared to the combined group, even after controlling for social support. They also had higher mean scores on the paranoid ideation subscale, but the difference was non-significant.

A pilot study by Pérez and Fortuna (2005) examined the incidence of psychiatric diagnoses and suicidal ideation in a convenience sample of outpatients at a New York City psychiatric facility. The sample consisted of undocumented Latino/a immigrants (n = 29), documented Latino/a immigrants (n = 144), and US-born Latino/as (n = 24). The authors stated the sample contained adult Latino/a patients of Mexican, South American, and Caribbean heritage, but they did not provide details about the sample's composition by specific Latino/a group. Suicidal ideation and psychiatric disorders were determined by reviewing patients' charts for the evaluating clinician's diagnosis and assessment of suicidal ideation. Similarly, documentation status was determined by reviewing the evaluating clinician's notes in the chart for any mention of documentation status. If this information was not available, the researchers assigned undocumented status by various combinations of methods including (a) consensus, (b) consulting the evaluating clinician, and (c) tagging charts of patients who lacked both a social security number and health insurance for further consultation with the evaluating clinician. This study found that undocumented Latino/a immigrants were more likely to be diagnosed with depressive disorders, anxiety disorders, adjustment disorders, and substance abuse disorders when compared to the other groups. There was little difference in suicidal ideation across groups, but a small trend for less suicidal ideation among documented Latino/a immigrants was noted.

A third study by Cavazos-Rehg, Zayas, and Spitznagel (2007) examined emotional distress in a snowball sample of adult Latino/a immigrants ($N = 143$). Participants were recruited from Catholic churches and a Latino/a community festival in a Midwestern city. Most of the immigrants (88 percent) were from Mexico. The participants were asked if they thought they would be deported if they went to a social service or government agency. Participants who gave an affirmative response to this question (39 percent) were designated as having an undocumented legal status. The "undocumented" group had a significantly higher mean score on the anger subscale of the Emotional Distress Scale (EDS) (Carver et al., 1993; as cited in Cavazos-Rehg et al., 2007) in comparison to the rest of the sample. There were no significant differences in EDS depression or anxiety subscale scores.

Finally, Potochnick and Perreira (2010) used a stratified cluster design to sample 218 Latino/a immigrant youth (70 percent Mexican) ages twelve to nineteen in North Carolina. Documentation status was assessed by parental self-report. They used logistic regression models to examine the role of documentation status in predicting clinically significant depression and clinically significant anxiety after adjusting for age, gender, stressful migration experience, social support, time in the US, discrimination and optimism. Compared to documented Latino/a adolescents, the odds of being depressed were 30.77 times greater for undocumented Latino/a adolescents who have a documented parent. Furthermore, the odds of having clinically significant anxiety were 8.59 times greater for undocumented Latino/a adolescents who have a documented parent and 6.29 times greater for undocumented Latino/a adolescents with an undocumented parent.

EXPLANATIONS OF UMI MENTAL HEALTH

Stress is well known as a predisposing factor and precipitant of psychiatric disorders (McEwen, 2004). We therefore examine chronic and acute stressors in a temporal order consistent with the three stages of the migration process (Foster, 2001; Loue, 2009): pre-migration stressors, peri-migration stressors, and post-migration stressors.

Pre-Migration Stressors

Pre-migration stressors for UMIs fall into two main categories in the literature: chronic poverty and family separation. Demographers, economists and political scientists have mostly analyzed pre-migration poverty indirectly at the macrosocial level. They have examined migratory trends, settlement patterns, and sociodemographic characteristics in relation to tests of various theories of migration. Their specific findings regarding UMIs' pre-migration demographic characteristics relevant to poverty are sometimes contradictory. For example, Marcelli and Cornelius (2001) found that UMIs' pre-migration educational levels increased dramatically starting in the 1970s, despite an association between increased education and greater financial

success within Mexico (Kandel & Massey, 2002). This result could suggest that poverty may not necessarily be a pre-migration stressor. Conversely, Durand, Massey and Zenteno (2001) found that UMIs' pre-migration educational levels decreased substantially during the same time period. In a study of whether or not greater border militarization deterred undocumented Mexican immigration, Cornelius and Salehyan (2007) found that it had very little impact on UMIs' decision to migrate, even after accounting for UMIs' knowledge of U.S. border control policies and the dangers associated with an undocumented border crossing. Cornelius and Salehyan concluded that for UMIs, US "restrictions on immigration are far outweighed by economic . . . incentives to migrate" (Cornelius & Salehyan, 2007, p. 149). UMIs' willingness to take such life-threatening risks for "economic incentives" suggests that poverty may be a strong pre-migration stressor.

Health and health services researchers have also examined economic factors as precipitants for undocumented migration. In the nursing literature, McGuire and Georges (2003) argued in their qualitative study of UMI health that neoliberal economic policies such as NAFTA have exacerbated poverty in Mexico to the extent that UMIs who arrive in the US are de facto "economic refugees" (p. 187). Other researchers have shown that poverty may be a common pre-migration stressor for UMIs. First, in a multi-site community probability survey of undocumented Latino/a's health care use (N = 973; 90 percent UMIs), the most common reason participants gave for migrating to the US was to find work (Berk, Schur, Chavez, & Frankel, 2000). Next, a study of adult Latina immigrants' (97 percent Mexican) access to health care in Fort Worth, Texas, found that undocumented immigrants were significantly more likely than documented immigrants to report that they migrated for work or economic reasons (Marshall, Urrutia-Rojas, Mas, & Coggin, 2005). In addition, all UMI's in a recent qualitative study indicated that they migrated to the US to escape chronic poverty in Mexico (Bacallao & Smokowski, 2007). Similarly, all participants in a study of apprehended UMI men in a detention facility cited economic hardship as the main reason they chose to migrate. Most of the men stated they planned to try to cross the border again despite the potentially lethal risks because they had no other options (DeLuca et al., 2010). Taken together, the findings from these studies portray a group of people whose economic situation in Mexico is distressing enough that they are willing to risk their lives crossing the US-Mexico border without documentation in order to find work.

Family separation may be a pre-migration stressor for UMIs, because of the anticipatory stress that it can produce (Carlson & Chamberlain, 2005). Mexican culture accords primacy to the bonds of family relationships, within and across generations, throughout a person's entire lifespan (Organista, 2007; N. Rodriguez, Mira, Paez, & Myers, 2007). The emphasis on the importance of family cohesion is noteworthy because the men were aware that by migrating, they risked the permanent dissolution of their families and that this dissolution might persist even after apprehension and deportation (DeLuca et al., 2010). Family separation may also be a powerful emotional stressor for those left behind, because the desire for family reunification

often serves as an incentive for other family members to migrate. For instance, UMIs often leave their children with relative and nonrelative caregivers because of the danger associated with crossing the border. These children frequently run away and try to cross the border on their own to reunite with their parents in the United States (L. R. Chavez, 1998; L. Chavez & Menjívar, 2010). Moreover, most UMI women in a Pacific Northwest study reported they had made repeated attempts to enter the US without documentation to reunite with family members (Andrews, Ybarra, & Miramontes, 2002). Finally, epidemiological research supports the notion that Mexicans experience separation from family members who have migrated to the US as a significant stressor. A recent national psychiatric epidemiologic study in Mexico found that the odds for suicidal ideation were 50 percent greater for Mexicans with a family member who had migrated to the US than for Mexicans without a family member who had migrated. This study also found that the odds for attempted suicide were 68 percent greater for Mexicans with a family member who had migrated than for Mexicans without a family member who had migrated to the United States (Borges et al., 2009).

Peri-Migration Stressors

Peri-migration stressors and traumas include the following issues: stressors and traumas related to being forced into hostile environmental terrain and stressors and traumas related to victimization by criminals, among others. Given the inherent difficulties of studying hidden populations like UMIs (Cornelius, 1982; Massey & Capoferro, 2004), the exact incidence of such stressors and traumas is unknown. In one study, however, most UMIs reported experiencing peri-migration stressors, including life-threatening dangers (Andrews et al., 2002). Most UMIs have been exposed to increased risk for peri-migration stressors and traumas associated with an unauthorized border crossing, and many are exposed repeatedly. Some researchers estimate that one-third of UMIs are apprehended while crossing the border without US government authorization and 92 percent to 97 percent keep trying to cross until they eventually succeed (Cornelius, 2005; Cornelius & Salehyan, 2007).

Stressors, Traumas, and Hostile Environment

The US-Mexico border has been described as the most militarized and deadliest border between two nations not at war (Massey & Riosmena, 2010; S. McGuire & Georges, 2003). To place the number of border deaths in perspective, the estimated number of Mexican migrants who died at the border from 1995 to 2004 was ten times greater than the number of East Germans who died at the Berlin Wall during its twenty-eight year existence (Rubio-Goldsmith, McCormick, Martinez, & Duarte, 2007). Consequently, the perilous experience of crossing the US-Mexico border is a shared source of traumatic stress among many UMIs (Foster, 2001; S. McGuire

& Georges, 2003), so much so that helping professionals who serve them are advised to routinely assess for symptoms of Post-Traumatic Stress Disorder (PTSD) (Hargrove, 2006; Zuniga, 2004).

Studies suggest a large proportion of UMIs likely experienced a threat to their physical well-being due to hostile environmental conditions while crossing the border. First, in a survey of 262,989 migrants apprehended by the border patrol from December 1999 to May 2000, 70 percent reported experiencing some type of environmental threat. Thirty-six percent of these migrants reported suffering extreme cold or extreme heat, and 35 percent reported suffering due to a lack of food or water (Cornelius, 2001). Next, qualitative studies of UMI border crossings are replete with themes of dehydration, starvation, exposure to extreme heat or cold, attacks by wild animals, and near-drowning (L. R. Chavez, 1998; L. Chavez & Menjívar, 2010; DeLuca et al., 2010; S. McGuire & Georges, 2003; Singer & Massey, 1998). Finally, studies have found that most migrant deaths along the border are attributable to environmental causes due to US border control policies. The top environmental causes of death are heat exposure, hypothermia, dehydration and drowning (Cornelius, 2001; Eschbach, Hagan, Rodriguez, Hernandez-Leon, & Bailey, 1999; Sapkota et al., 2006).

Many UMIs are exploited and victimized by criminals while crossing the border. For instance, Mexican migrants often pay human smugglers to help them cross the border (Cornelius, 2001; Cornelius & Salehyan, 2007; Hagan & Phillips, 2008; Massey & Riosmena, 2010). There are reports in the literature of smugglers (a) kidnapping UMIs and subjecting them to forced labor to work off "extra costs" (Foster, 2001; Gushulak & MacPherson, 2000); (b) raping UMI women (Andrews et al., 2002; Foster, 2001; Solis, 2003) and (c) robbing and abandoning migrants in remote locations (Andrews et al., 2002; L. Chavez & Menjívar, 2010; DeLuca et al., 2010). UMIs report being attacked and robbed by border bandits, and they are victimized and killed by armed nativist paramilitary vigilantes on the US side of the border (L. R. Chavez, 1998; Cornelius, 2005; DeLuca et al., 2010; Smith, 2011; Vargas, 2001; Zuniga, 2004). Finally, apprehended migrants often experience severe trauma at the hands of US Border Patrol agents (Vargas, 2001). The US Border Patrol's use of excessive force, beatings and racially motivated psychological abuse has been described as "routine" (Vargas, 2001, p. 42). Other abuses perpetrated by the US Border Patrol include unprovoked shootings, rape, sexual assault, torture, denial of food and water, and the withholding of medical care (Hagan & Phillips, 2008; Solis, 2003; Trevino, 1998; Vargas, 2001; Zuniga, 2004). Vargas (2001) noted that

> the atrocities and brutal abuses inflicted by US Border Patrol agents upon undocumented Mexican nationals have been so numerous and egregious, that this untenable situation finally raised the attention of the US Congress. In 1994 and again in 1997 . . . the US House of Representatives held special hearings to address the questions [and] investigate these abuses (p. 55)

Post-Migration Stressors

After arriving in the US, UMIs continue to endure a set of chronic stressors that give them a unique risk profile for psychiatric morbidity compared to documented and US-born Mexicans (Sullivan & Rehm, 2005). Common post-migration stressors among UMIs include documentation status anxiety; exploitation and victimization; social isolation; limited access to healthcare; poverty; and discrimination (Bustamante et al., 2010; L. R. Chavez, 1998; Fussell, 2011; Goldman, Smith, & Sood, 2005; S. McGuire & Georges, 2003; Ortega et al., 2007; Sullivan & Rehm, 2005). The song "Juala de Oro" ("The Gilded Cage") contains the following verses:

> *¿De qué me sirve el dinero si yo soy como prisionero dentro esta gran nación? Cuando me acuerdo hasta lloro aunque la jaula sea de oro, no deja de ser prisión . . . De mi trabajo a mi casa. Yo no sé lo que me pasa aunque soy hombre de hogar. Casi no salgo a la calle pues tengo miedo que me hallen y me pueden deportar.*
>
> What good is money if I am like a prisoner in this great nation? When I think about it, I cry. Even if the cage is made of gold, it doesn't make it less of a prison . . . From my job to my home. I don't know what is happening to me. I am a homebody. I almost never go out to the street. I am afraid I will be found and could be deported. (L. R. Chavez, 1998, pp. 160–61)

An undocumented immigration status can be a chronic stressor that infuses most aspects of UMIs' lives with constant fear of deportation (Dozier, 1993; S. McGuire & Georges, 2003; Shattell, Hamilton, Starr, Jenkins, & Hinderliter, 2008; Sullivan & Rehm, 2005). The US has been described as a "deportation regime" (De Genova & Peutz, 2010, as cited in Boehm, 2011, p. 12) that inflicts a "culture of terror" (Scheper-Hughes & Bourgois, 2004, as quoted in Boehm, 2011, p. 12) on UMIs. The constant threat of apprehension and deportation creates a climate of fear among UMIs that can lead to hyper-arousal and hypervigilance, conditions known to be conducive to greater stress response (Carlson & Chamberlain, 2005; S. McGuire & Georges, 2003).

Qualitative and quantitative studies suggest documentation status anxiety is indeed a powerful stressor for UMIs. In qualitative studies, UMIs have reported feeling terrorized by the constant threat of deportation and having nightmares about being apprehended and deported by immigration authorities (L. R. Chavez, 1998; Safdie, 2009). Fear of deportation due to being undocumented also emerged as a pervasive theme in a qualitative study of access to mental health services among Latino/as (Shattell et al., 2008). In addition, documentation status anxiety causes UMIs to engage in "fear-based behaviors" (Sullivan & Rehm, 2005, p. 248) to avoid detection by immigration authorities such as not seeking needed medical treatment, not reporting instances of victimization, and self-isolation (L. R. Chavez, 1998; S. McGuire & Georges, 2003; Safdie, 2009; Sullivan & Rehm, 2005).

Quantitative studies have also found that undocumented Latino/a immigrants experience their immigration status as a major stressor. In one study, undocumented Latino/as reported a significantly higher mean number of psychosocial stressors in

comparison to documented and US-born Latino/as, and they were more apt to report immigration status-related stressors than their counterparts (Pérez & Fortuna, 2005). Further, a recent study found that undocumented Latino/a immigrants suffer from significantly greater legal status anxiety in comparison to documented Latino/as (Arbona et al., 2010). Finally, legal status anxiety has been found to be related to increased stress among undocumented male Latino migrant day laborers (de Castro, Voss, Ruppin, Dominguez, & Seixas, 2010) and greater depression in a sample of Mexican immigrants with unknown documentation statuses (Finch, Kolody, & Vega, 2000).

Because of their documentation status, UMIs are especially vulnerable to exploitation and victimization (Bucher, Manasse, & Tarasawa, 2010; Fussell, 2011; Sullivan & Rehm, 2005). Mechanisms of this increased vulnerability include immigrants' fear of deportation and perpetrators' use of that fear (Bucher et al., 2010; Fussell, 2011). UMIs are disproportionately the victims of robbery, assault, and they are significantly more likely to experience labor exploitation in comparison to documented immigrants (Bucher et al., 2010; de Castro et al., 2010; de Janvry, Sadoulet, Davis, Seidel, & Winters, 1997; Fletcher, Pham, Stover, & Vinck, 2006; Fussell, 2011; Gorman, 2010; Phillips & Massey, 1999; Sabates-Wheeler, 2009; Valenzuela, Theodore, Meléndez, & Gonzalez, 2006; Vinck, Pham, Fletcher, & Stover, 2009). UMIs are considered attractive targets for assault and robbery by criminals for several reasons. First, they generally do not have bank accounts. Perpetrators know that UMIs tend to carry large sums of cash and/or store large sums of cash in their homes—criminals often refer to them as "walking ATMs" (Bucher et al., 2010; Fussell, 2011). In addition, perpetrators are also aware that their UMI victims are unlikely to contact the police because they fear being deported (Bucher et al., 2010; Fussell, 2011). Moreover, many criminals assume that most UMIs cannot speak English well enough to file a police report (Bucher et al., 2010).

UMIs are vulnerable to employers who exploit their immigration status and reluctance to report workplace abuses due to fears of deportation (Bucher et al., 2010; Fussell, 2011; Gleeson, 2010). Employers exploit UMIs' fear of deportation to cut costs by not paying or underpaying UMIs and ignoring occupational safety regulations (Gleeson, 2010; Vinck et al., 2009). According to Lee (2009), many employers

> report workers in retaliation for unauthorized immigrants attempting to assert their labor and employment rights. Employers, therefore, possess a great deal of discretion over whom they hire and whom they report, and in both instances it appears they exercise that discretion in a manner that elevates their interest in maximizing profit . . . [E]mployers are best understood as private immigration screeners who identify potentially unauthorized immigrants within their workforces for removal. . . . [They] shape the conditions under which unauthorized immigrants remain in the United States and define the conditions triggering [ICE] detention and removal. (pp. 1107–9)

An undocumented status has been found to suppress an immigrant's earnings regardless of educational level, English proficiency, and length of residence in the

United States (Mehta, Theodore, Mora, & Wade, 2002). Next, UMIs are routinely victims of wage theft, and they experience it at a higher rate compared to documented immigrants (Fletcher et al., 2006; Fussell, 2011; Vinck et al., 2009). A recent study of mostly undocumented Mexican day laborers found that approximately half reported at least one instance of wage theft in the preceding two months (Valenzuela et al., 2006). Knowing UMIs lack legal recourse, some employers simply refuse to pay UMI workers and threaten to call ICE if the workers complain. One of the most common abusive employer practices is to overwork UMIs, who have identified physically exhausting labor as a major stressor (Bacallao & Smokowski, 2007). Employers either overtly refuse to allow UMIs to take lunch and bathroom breaks or create rules tying productivity to payment that are so difficult to meet that UMIs "voluntarily" abdicate lunch and bathroom breaks (Holmes, 2006; Valenzuela et al., 2006). In a study by Valenzuela and colleagues (2006), 44 percent of day laborers reported that an employer had denied them food and/or bathroom breaks in the preceding two months. In addition, studies have shown that undocumented workers are more likely to experience hazardous working conditions in comparison to documented workers (Fletcher et al., 2006; Mehta et al., 2002; Vinck et al., 2009). Due to their undocumented status, they are at an exceptionally high risk for work injury (de Castro et al., 2010; Walter et al., 2004). Latino/a immigrants in general have been found to have higher rates of workplace injury and fatality in comparison to other immigrants (de Castro et al., 2010), possibly because a large portion of Latino/a immigrants are undocumented. UMIs are therefore over-represented in some of the lowest-paying and most dangerous occupations such as agricultural work and construction (Farquhar et al., 2008; Passel & Cohn, 2009; Walter, Bourgois, & Margarita Loinaz, 2004).

Difficulty accessing health care has been identified as a stressor for undocumented Latino/a immigrants (Pérez & Fortuna, 2005). Immigration status-related concerns, such as fear of deportation or denial of treatment, cause many UMIs to delay or avoid seeking care (Berk et al., 2000; Berk & Schur, 2001; Bustamante et al., 2010). For example, 39 percent of a sample of undocumented Latino/a immigrants from a multisite survey of undocumented Latino/a immigrants expressed fear related to receiving medical treatment due to their documentation status. The number of undocumented Latino/a immigrants expressing fear across the four sites ranged from 34 percent to 45 percent. Furthermore, those undocumented immigrants who reported fear related to receiving medical treatment were substantially less likely to obtain needed medical treatment compared to those who did not report fear (Berk & Schur, 2001). Findings regarding the rate of health insurance for UMIs and undocumented Latino/a immigrants vary across studies and range from roughly 10 percent (Marshall et al., 2005; Nandi et al., 2008; Urrutia-Rojas, Marshall, Trevino, Lurie, & Minguia-Bayona, 2006) to 47 percent[3] (Bustamante et al., 2010). However, all studies have found that undocumented immigrants have significantly lower rates of health insurance compared to documented immigrants (Bustamante et al., 2010; Goldman et al., 2005; Marshall et al., 2005; Urrutia-Rojas et al., 2006). Similarly, studies have shown that UMIs and undocumented Latino/as are substantially less

likely to have access to a usual source of medical care (Bustamante et al., 2010; Marshall et al., 2005; Ortega et al., 2007; Urrutia-Rojas et al., 2006). These results are concerning given findings that (a) UMIs and undocumented Latino/a immigrants have high rates of poor self-reported health (de Castro et al., 2010; Urrutia-Rojas et al., 2006), and (b) UMIs have worse self-reported health compared to their documented counterparts (Ortega et al., 2007; Urrutia-Rojas et al., 2006). For example, despite being much younger compared to documented Mexican immigrants in one study, UMIs were eleven times more likely to report their health as poor (Urrutia-Rojas et al., 2006).

Poverty is an important post-migration stressor among undocumented Mexican immigrants. Researchers using state and national probability survey data have found that UMIs are more likely to live in poverty in comparison to documented Mexican immigrants and US-born Mexican Americans. Two studies of different random-digit telephone population-based surveys in California[4] found that UMIs are more likely to live below the federal poverty line in comparison to other Mexican-origin adults in the US. First, Ortega and colleagues (2007) found significant differences in the percentage of Mexican-origin adults living below the federal poverty threshold by immigration status as follows: US-born (14.0 percent); naturalized citizens (21.0 percent); green card holders (35.9 percent); UMIs (55.1 percent). Second, Bustamante and colleagues (2010) found that a significantly greater percentage of UMIs lived below the federal poverty line compared to documented Mexican immigrants, at 54.98 percent and 28.98 percent, respectively. At the national level, Garcia (2011) analyzed 2000 census data and found that for Mexican immigrants, after controlling for other socio-demographic covariates, being undocumented[5] (a) increased the odds of living at or below the federal poverty threshold by 114 percent; (b) increased the odds of living in extreme poverty (defined as being at or below 50 percent of the federal poverty threshold) by 246 percent; (c) increased the odds of being classified as low income[6] (defined as being at or below 200 percent of the federal poverty threshold) by 328 percent.

The high poverty rate among UMIs places them at risk for related pathogenic stressors (stressors associated with physical and psychiatric disorders) including food insecurity and high household density (Garcia, 2011; Hadley et al., 2008; Hill, Moloney, Mize, Himelick, & Guest, 2011; Standish, Nandi, Ompad, Momper, & Galea, 2010). Among UMIs, food insecurity has been found to be associated with an increase in the number of past-month self-reported days of poor mental health (Hadley et al., 2008). Finally, a study of household density among UMIs found greater density to be related to an increase in the number of past-month self-reported days of poor mental health and experiencing food insecurity during the past six months (Standish et al., 2010).

Discrimination is defined as behavior engaged in by individuals or groups that involve disparate treatment of members of a specific group, including contempt, ridicule, degradation, and derision, and it occurs across a variety of domains (Sanders Thompson, 2006). It is now acknowledged that discrimination is a chronic, unpredictable,

and uncontrollable stressor—precisely the type of stressor known to have especially adverse physical and mental health consequences (Pascoe & Smart Richman, 2009; Williams & Mohammed, 2009). In addition, studies have established that perceived discrimination is associated with an array of adverse mental health outcomes (Araújo & Borrell, 2006; Gee, Ryan, Laflamme, & Holt, 2006; Pascoe & Smart Richman, 2009; Williams & Mohammed, 2009).

Mexicans in the US may perceive discrimination due to documentation status, skin color, ethnicity and/or English proficiency (Córdova & Cervantes, 2010; Dovidio, Gluszek, John, Ditlmann, & Lagunes, 2010). Like Latino/as generally, they are a heterogeneous population in terms of skin color, ethnicity, and English proficiency, and their specific experiences of discrimination may vary accordingly (Dovidio et al., 2010; Pérez, Fortuna, & Alegría, 2008). UMIs are subject to both intergroup (i.e., from the broader US society) and intra-group (i.e., from other Latino/as including Mexican-origin people in the US) discrimination due to their documentation status and, perhaps increasingly, their skin color (Darity, Dietrich, & Hamilton, 2005; Fox, 2006; Holmes, 2006; Johnson, 1998; Lavariega, Monforti & Sanchez, 2010; S. McGuire & Canales, 2010; Uhlmann, Dasgupta, Elgueta, Greenwald, & Swanson, 2002).

UMIs are a hidden population, so there are no exact statistics on their racial and ethnic composition. Seasoned researchers engaged in fieldwork among the *indígenas*—members of Mexico's marginalized, dark-skinned indigenous communities—have stated that most UMIs have indigenous heritage (S. McGuire, personal communication 3/12/11), and the literature appears to corroborate this assertion. Research suggests that *indígenas* comprise a large and fast-growing sector of the UMI population. Following President Clinton's successful implementation of NAFTA (1994), the US raised farm subsidies 300 percent, whereas Mexico has continually reduced subsidies for corn production, a primary means of subsistence for Mexico's indigenous communities. The result was the massive displacement of rural *indígenas* who were forced to migrate to the US for work (Holmes, 2006). Moreover, Riosmena and Massey (2010) noted a shift in Mexican migration patterns to the US related to sending communities. Mexico's central and southeastern states have the largest indigenous populations (Fox, 2006), and these states now account for almost 40 percent of Mexican migration to the United States (Massey & Riosmena, 2010). An estimated 90 percent of migrants from these regions are undocumented, which is significantly higher compared to all other regions (Massey & Riosmena, 2010). In another study, 57 percent of migrants from Mexico in suburban Atlanta self-identified as "indigenous" instead of "Mexican" (Arizpe, 2007).

If *indígenas* comprise a large sector of UMIs, then UMIs as a group are likely subject to racial discrimination more often compared to documented Mexican immigrants. In Mexico's rigidly stratified colorist society, skin color is the primary predictor of wealth and social class even after controlling for other soicodemographic covariates (de Leff, 2002; Villarreal, 2010). The tiny minority of white Mexicans who claim pure Spanish ancestry are at the top of this hierarchy, and the dark-

skinned *indígenas* are at the bottom (de Leff, 2002). Given the income requirements for a visa, undocumented migration to the US is generally the most viable option available to the indigenous populations and Mexicans with darker skin—the wealthy white Mexican aristocracy would not need to risk an undocumented border-crossing if they wanted to migrate to the United States. Consequently, researchers have implied that Mexican immigrants have brought Mexico's colorist system with them to the US (Fox, 2006), which suggests that UMIs may be disproportionately subject to intra-group racial discrimination.

CONCLUSION

UMIs confront a distinct constellation of stressors before, during, and after migrating to the United States. Researchers have suggested that these stressors may place them at greater risk for mental health problems and psychiatric morbidity (rate of incidence) compared to their documented counterparts (Sullivan & Rehm, 2005). Yet there is a dearth of research on the mental health of UMIs. No studies have used a standardized psychodiagnostic interview to examine the prevalence of psychological symptomatology and psychiatric disorders among UMIs in a nationally representative sample of Latino/a adults.

This analysis also suggests that UMIs might have worse mental health compared to documented Mexican immigrants, US-born Mexican Americans, and other Latino/as in the United States. Consistent with this analysis, prior research related directly to UMI mental health, while scarce, tentatively suggests that UMIs experience a greater number of stressors and worse mental health compared to documented Latino/a immigrants and US-born Latino/as (Cavazos-Rehg et al., 2007; Potochnick & Perreira, 2010; Pérez & Fortuna, 2005; R. Rodriguez & DeWolfe, 1990).

Despite well-known obstacles, future research should attempt to examine differences in physiological indicators of stress reactions among UMIs, documented Mexican immigrants, US-born Mexicans, and other US Latino/as and the relationship among these physiological indicators, documentation status and mental health. In conjunction with validated instruments to assess mental health problems and psychiatric disorders, researchers should also include instruments that assess a lifetime number of traumatic events, exploitation and victimization, poverty, family separation, and perceived discrimination. It is also important that future psychiatric epidemiological studies take steps to improve recruitment of UMIs in order to enhance the population validity vis-à-vis Mexican immigrants in nationally representative probability samples. Doing so would enable researchers to better understand the relationship between documentation status and mental health and may allow them to test whether or not prior findings of a Mexican-specific mental health paradox were due to a methodological artifact, i.e., the systematic under sampling of UMIs—the largest sector of the Mexican immigrant population with a potentially greater risk for mental health problems and psychiatric disorders. Finally, researchers should

explore the use of statistical modeling techniques to estimate characteristics of UMIs in existing nationally representative psychiatric epidemiological studies that contain sufficient socio-demographic information and immigration-related questions but do not directly ask about documentation status. Latent class analysis and multiple imputation modeling are two potentially viable techniques that warrant further methodological investigation.

Subtle shifts in U.S. policy may ease some of the stressors that UMIs face. For example, the new rules loosening deportation for a segment of the UMI population may ease post immigration stress. Under the new rules, deportation will no longer apply to immigrants who came into the country before they were sixteen and are now younger than thirty, have lived here for five straight years, have never been convicted of a crime, graduated from high school or got a GED. However, the anxiety associated with determining the impact of shifting US immigration policy may increase anxiety for some. For example, a proposed law known as the DREAM Act, which is strongly supported by the Pentagon, would provide undocumented immigrant young adults with a path to citizenship if they complete college or serve in the military for two years. The cost of college is prohibitive for the majority of undocumented youth, most of whom would have no choice but to take the military option—and one cannot enlist in the military for only two years (Mariscal, 2007). Serving in the military during a time when the United States is at war and has troops occupying Iraq and Afghanistan could be a pathogenic stressor for UMIs forced to enlist in the military (and their families) if the DREAM Act is passed.

Finally, while undocumented status may affect the incidence and prevalence of psychiatric symptoms and disorders, research suggests that it is very likely to affect the willingness to seek services for identified needs. Given the significance of the UMI population in the United States, it will be important to develop systems and resources that are capable of outreach to the population to assure appropriate service utilization. It is increasingly important that the mental health workforce be trained to deliver culturally competent services, including linguistically appropriate services, and services that are sensitive to the high levels of stress and trauma exposure associated with the UMI experience.

NOTES

1. IRCA contained an "amnesty" provision that allowed undocumented immigrants meeting certain criteria to apply to the US government for legal residence.

2. Documented immigrants had the highest level of social support, followed by UMI women who qualified for legal residence, while the UMI women who did not qualify to apply for legal residence had the least social support.

3. This study was based on a probability sample of California residents with landline phones. Lower-income segments of the population such as UMI farmworkers were systematically underrepresented by this sampling frame.

4. The use of random-digit telephone sampling underrepresents UMIs because UMIs are more likely to be among non-respondents and those without telephones (Bustamante et al., 2010; Ortega et al., 2007).Both studies may have under-estimated UMI poverty rates.

5. Undocumented legal status was a conservatively constructed proxy variable based on other sociodemographic indicators derived from the demography literature (see Garcia, 2011, for details).

6. This category was constructed because research shows that persons classified as low income in the US share the same risk factors as the two lower poverty groups and that the method for calculating the poverty threshold in the US underestimates actual poverty (see Garcia, 2011, for an extensive discussion).

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21

The Intersection of Poverty and Health

Are Race and Class Far Behind? A Case Study

Vetta L. Sanders Thompson and Anjanette Wells

> *In poor countries, tragically, people die unnecessarily. In rich countries, too, the higher death rate of those in less fortunate social positions is unnecessary. Can there be a link between these two phenomena: inequalities in health among countries and inequalities within?*
>
> *The unnecessary disease and suffering of the disadvantaged, whether in poor countries or rich, is a result of the way we organize our affairs in society.*
>
> —Michael Marmot (2006)

Measures of health status have highlighted disparities in the health of African Americans compared to other racial and ethnic groups in the United States. African Americans are more likely to self-report that their health is fair or poor, and this issue is illustrated most prominently in central-city urban communities (Murray, Kulkarni, Michaud, Tomijima, Bulzacchelli, Iandiorio, & Ezzati, 2006). Statistics suggest that the situation is most critical for African American men. For the purposes of this chapter, African or Black Americans are the descendants of any of the black racial groups of Africa. African Americans are currently the third largest ethnic group in the United States, with a population of 43.2 million or 14.1 percent of the total population (US Census Bureau, 2011). Of the total population, based on the 2010 U.S. Census, 13.1 percent reported Black or African American as their only race. The remaining members of the population, or 1.0 percent, reported this racial classification in combination with one or more races. This chapter provides an overview of the health status of African Americans, describes the nature of the health disparities observed, and illustrates how poverty and associated factors contribute to disparities in health outcomes using data from an urban central city, St. Louis, Missouri.

Table 21.1. African American Comparative Health Statistics

	All Races		*White*		*African American*	
Measure	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*
Life expectancy at birth, 2007	75.4	80.4	75.9	80.8	70.0	76.8
Age-adjusted death per 100,000, 2007	905.6	643.4	890.5	634.8	1184.4	793.8
Infant mortality rate, 2006 (per 1,000 live births)	7.0		5.6		13.4	
Maternal mortality rate, 2002 (per 100,000 live births)	7.6		4.8		22.9	

Data sources: CDC Health Data Interactive, 2010, http://205.207.175.93/HDI/TableViewer/tableView.aspx, Life Expectancy at birth; http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_19.pdf; CDC 2010. Infant Mortality Statistics from the 2006 Period Linked Birth/Infant Death Data Set. *National Vital Statistics Reports*. Table 2. http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_17.pdf [PDF | 592.25KB]; Maternal Mortality, 2002 National Center for Health Statistics, Health, United States, 2004, Table 43.

OVERALL HEALTH STATUS

As is true of health in the United States in general, African American health has improved; however, African American life expectancy is lower with life expectancy at birth at 73.6 years compared to 78.4 for Whites and 77.9 for all races combined (National Center for Health Statistics, 2010). African American men have a lower life expectancy than men of other racial and ethnic groups and African American women. Continuing the trend toward improved health, in 2008, African Americans showed significant decreases in age-adjusted death rate; although the age-adjusted death rate for African Americans was higher than that of the general population (National Center for Health Statistics, 2010). Non-Hispanic Black males and females had a 1.9 percent and 1.5 percent decrease in age-adjusted death rate, respectively (Murphy, Xu, & Kochanek, 2012).

On one of the most sensitive indices of health status, infant mortality, African Americans have 2.4 times the infant mortality rate of non-Hispanic Whites and are four times as likely to die as infants due to complications related to low birth weight as compared to non-Hispanic white infants (Office of Minority Health, 2011a). Maternal death occurs at 3.3 times the rates of non-Hispanic white women (Kung, Hoyert, Xu, & Murphy, 2008). In addition, the self-rated health status of African American elders is lower than the self-rated health status of the total population (Administration on Aging, 2010).

In 2008, the ten leading causes of death for African Americans were (in order): heart disease, cancer, stroke, unintentional injuries, diabetes, respiratory disease, kidney disease, homicide, septicemia (bacteria in the blood), and human immunodeficiency virus (HIV) (Heron, 2012). The top two causes of death are similar to those found in the general population, although the mortality rates observed

among African Americans are higher. The most significant differences compared to the general population are deaths due to homicide, septicemia and HIV. Among African Americans homicide ranked eighth, septicemia ninth, and HIV disease tenth as leading causes of death, but these causes were not ranked among the top ten for other racial groups, and only homicide appears in the top ten leading causes of death among Hispanics (Heron, 2012). In addition, diseases such as asthma are higher among African American children and adults (Heron, Hoyert, Murphy, Xu, Kochanek, & Tejada-Vera, 2009).

As is true in the general population, most causes of death have been declining among African American elders (Administration on Aging, 2010). However, lung cancer and deaths from other lung diseases have increased among older African American men and women (Sahyoun, Lentzner, Hoyert, & Robinson, 2001). There has also been an increase in mortality associated with hypertension (Sahyoun et al., 2001). The leading causes of death for African Americans sixty-five years of age and older were the same for the top three causes of death, but older African Americans are less likely to die from unintentional injuries and homicides than their younger counterparts (Heron, 2012).

Health behaviors also play a role in overall health. African Americans are more likely to have lower rates on positive and higher rates on negative health behaviors. African Americans were less likely to meet the fruit and vegetable intake guidelines compared to non-Hispanic whites (Casagrande, Wang, Anderson & Gary, 2007), with only 21.5 percent of African American adults reporting that they ate five or more fruits and vegetables per day (Kruger, Yore, Solera, & Moeti, 2007). African Americans often report that they lack a usual source of care and are less likely to have a yearly dental exam (Kaiser Commission, 2000). The trend toward increasing obesity is greater among African American adult females, with a 77.3 percent prevalence of overweight and obesity (Kruger et al., 2007). African Americans tend to live in environments with poorer housing quality and disproportionately live in areas where the air contains one or more commonly found air pollutants, including ozone (Miranda, Maxson, & Edwards, 2009). Low-income and African American children are also at increased risk of lead poisoning (US Environmental Protection Agency, 2008).

HEALTH DISPARITIES

Definitions differ, but generally, health disparities refer to differences in health status, not based on biology, that are experienced by populations and are assumed to be related to differences in social status, including education, income, and access to care (Brach & Fraser, 2000). African American mortality rates are higher than those of Whites and they have the highest rates of morbidity and mortality of any US racial and ethnic group (National Center for Health Statistics, 2012). African Americans tend to have the highest rate of hypertension of all groups and tend to develop it younger than others (National Center for Health Statistics, 2010).

According to the National Center for Health Statistics (2010), African Americans have higher rates of diabetes-related complications, such as kidney disease and amputations. Further, the incidence of stroke is disproportionately high among African Americans, and the mortality rate is higher than among Whites (National Center for Health Statistics, 2010). Age-adjusted death rates from asthma were higher among African Americans. African Americans and Hispanics have higher rates of sexually transmitted diseases than Whites (National Center for Health Statistics, 2010). According to Witt (2006), the poorer health status of African American men is well documented. African American men have a higher death rate from diabetes, heart disease and HIV/AIDS than men of other racial and ethnic groups (Office of Minority Health, 2012a). Among all racial and ethnic groups, African American men had the highest cancer incidence and mortality rates for all sites combined. African American men had higher incidence and mortality rates for prostate, lung, colorectal, and other specific cancers (Jemal, Siegel, Ward, Hao, Xu, Murray, & Thun, 2008).

There are also disparities in several of the leading health indicators. For example, diets high in fat and calories and low in fruits, vegetables and fiber, and physical inactivity increase the risk of diabetes, hypertension, heart disease, and cancer (Taylor, Poston, Jones, & Kraft, 2006). Compared to Whites, African Americans consume higher amounts of dietary fat and lower amounts of fruits, vegetables and dietary fiber and are more likely to report no leisure-time physical activity (Kruger, Yore, Solera, & Moeti, 2007). According to data from the National Health and Nutrition Examination Survey (NHANES), overweight is more prevalent among African Americans than non-Hispanic Whites (Office of Minority Health, 2012b).

FACTORS ASSOCIATED WITH AFRICAN AMERICAN HEALTH DISPARITY

While we cannot pinpoint the specific causes of health disparity for specific diseases among members of particular social categories, we can say that race, class, and gender do not in and of themselves produce health disparities (Geiger, 2003). Disparities in African American health status are explained by a number of factors, including income; lack of education and unemployment; differences in lifestyles and health behaviors, such as diet, nutrition and physical activity; differences in environmental and occupational risks and hazards; and cultural beliefs about health as well as discrimination and access to healthcare (Geiger, 2003). There is evidence that each of these factors play a role in health disparities.

Social determinants may also influence health outcomes through their influence on health-related behaviors. Thomas Laveist noted, "Because of substantial segregation in the United States, members of different racial/ethnic groups have substantially different levels of exposure to social health risks as well as to environmental toxins" (Laveist, 2005, p. 136). Inequities in health outcomes and social conditions

have also been associated with differences in health-related behavioral factors such as tobacco use, exercise, diet, and participation in screening for various health risks. Similarly, communities with higher unemployment rates had higher rates of smoking and a higher consumption of calories from fat (Lee & Cubbin, 2002). Studies have also found that individuals living in geographic areas that are economically depressed may have less access to healthful food options and activity-friendly communities than individuals living in more prosperous areas (Taylor, Poston, Jones, & Kraft, 2006; Zenk, Schulz, Israel, James, Bao, & Wilson, 2005).

Studies by the Commonwealth Fund indicate Hispanic and African American working-age adults are at greater risk of experiencing gaps in insurance coverage, lacking access to health care, and facing medical debt than White working-age adults (Collins, Davis, Doty, Kriss, & Holmgren, 2006). The rate of uninsured African Americans is higher than that of Whites, but lower than that of Hispanics (Collins et al., 2006). Individuals without insurance are more likely to delay care and screenings, less likely to obtain needed medications, and more likely to be diagnosed at later stages of illness (Collins et al., 2006; DeNavas-Walt, Proctor, & Hill Lee, 2006). These patterns of access to and use of healthcare are associated with increased morbidity and mortality from disease.

Data indicate that African American adults are more likely to visit an emergency room for a condition that could have been treated by a doctor in an office setting if routine healthcare were available (DeLia & Cantor, 2009). In addition, African Americans are less likely to receive preventive health screenings and immunizations. For example, African Americans and Hispanics are less likely than Whites to receive influenza or pneumonia vaccines, and rates of cholesterol and blood pressure screenings are also lower (National Commission on Prevention Priorities, 2007).

The official US poverty rate increased between 2008 and 2010 and was 15.1 percent compared to 13.2 percent in 2008 (DeNavas-Walt, Proctor, & Smith, 2011). Between 2008 and 2010, the poverty rate increased for non-Hispanic Whites (from 8.6 percent to 9.9 percent), for Blacks (from 24.7 percent to 27 percent), and for Hispanics (from 23.2 percent to 26 percent). For Asians, the 2010 poverty rate (12.1 percent) was not statistically different from the 2008 poverty rate (DeNavas-Walt et al., 2011). Unemployment is significantly higher among African Americans and Hispanics, as well (US Department of Labor, 2012). Even better-off African Americans are often the first generation in their family to achieve middle-class status and are likely to lack the wealth accumulated by White families of similar economic status, meaning they have fewer economic resources to access during an extended illness or healthcare crisis (Shapiro, 2004). And while rates of high school graduation and college completion have increased, African Americans continue to be less well educated than Whites (Education Week, 2011). Because of decreased educational levels and personal resources, the awareness of health problems, knowledge of causes and risk factors, and capacity to access medical care may be greatly decreased (Wolf, Davis, & Parker, 2007). Low income and lack of education are associated with increased morbidity and mortality from disease, increased obesity, decreased physical activity,

lack of insurance and health care access (Link & Phelan, 1996; Kidder, Wolitski, Campsmith, & Nakamura, 2007).

Studies indicate that the socioeconomic explanation of disparities is limited. African Americans and other minorities are less likely to have a usual source of care, and African American patients have been found to receive a lower quality of care than White patients treated for heart failure and pneumonia (Agency for Healthcare Research and Quality, 2000). There were no differences in the quality of care between patients from poor communities compared to other patients. Among pre-school children treated for asthma in the hospital, fewer African American and Hispanic children were prescribed routine medications to prevent future hospitalizations (Agency for Healthcare Research and Quality, 2000).

Discrimination may affect disparities through the historical existence of social inequity and injustice in American education, justice, and economic structures and the disadvantages that have accrued to African Americans based on these differences (LaVeist, 2005). In addition, discrimination may influence disparities through the biases of healthcare institutions and providers. It has been suggested that providers may offer less intensive and sophisticated treatment options to African American patients due to stereotyped beliefs about ability to pay and willingness or ability to engage in and/or accept these services. These biases have been most clearly observed and documented for cardiac care (Agency for Healthcare Research and Quality, 2000).

HEALTH DISPARITY AND THE ST. LOUIS CASE

It is generally accepted (Institute of Medicine, 2003) that socio-economic factors such as income, education, employment, and access to health insurance have an influence on both health outcomes (mortality, chronic disease, disability) and health behaviors (diet, physical activity, and tobacco use). In 1988, Harpham, Lusty, and Vaughan modeled the direct, environmental, and psychosocial factors that contribute to disease among the poor. The direct factors included unemployment, low income, limited education, inadequate diet, and prostitution. Environmental factors were mainly associated with water quality, sanitation, overcrowding, poor housing, garbage accumulation, lack of space for a garden, traffic, industrialized hazards, pollution, and accidents. St. Louis, Missouri, has characteristics that illustrate this model.

St. Louis, with a current population of 319,294, is one of the most racially segregated cities in the United States (Gordon, 2008). It is unique in that it is the only city within the state of Missouri and one of the few in the country that operates as both a city and a county. Due to St. Louis City's unique status as a home rule city separated from St. Louis County, St. Louis City government provides both county and municipal governance and services. The St. Louis African American population, which in 1999 surpassed the White population as the City's majority group at 51 percent (Parish, 2001), at one time resided almost exclusively in the northern half

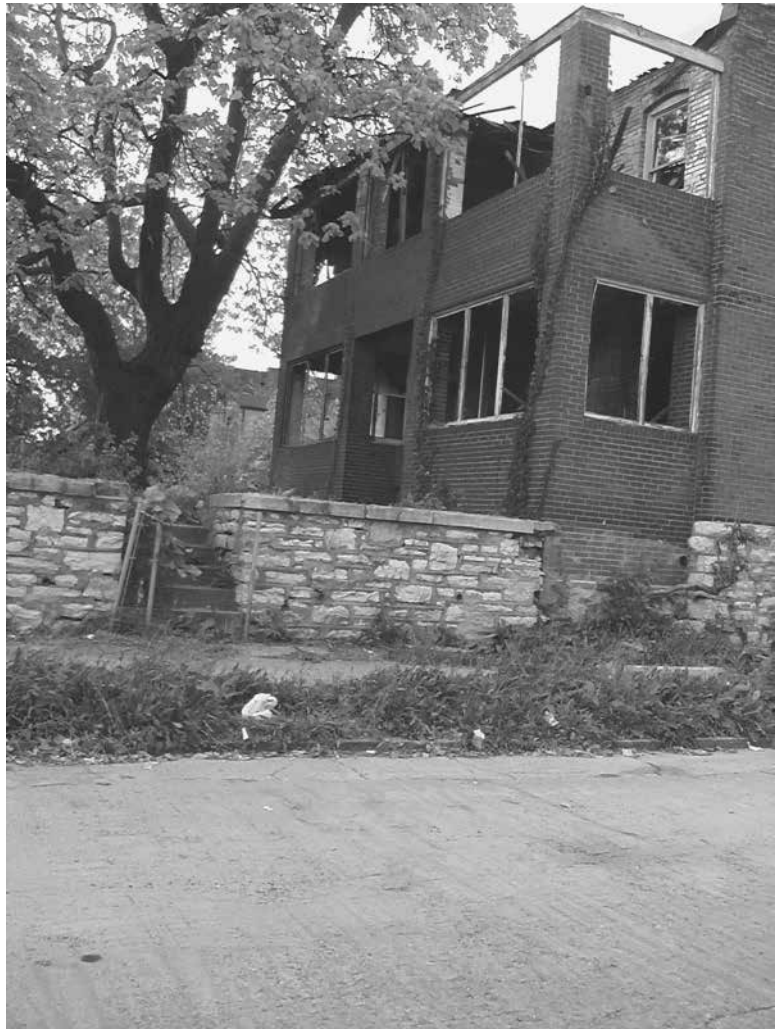

Figure 21.1. Deteriorating Housing Stock, North St. Louis City.

of the city. During the 1990s, the African American population began migrating in two general directions: North into St. Louis County and south into the City's central corridor. Additionally, during the same decade, St. Louis suffered major population loss (-15.8 percent) (Branch-Brioso, 2000).

The most recent population data indicate that since 2000 St. Louis City lost 8.3 percent of its population, or 28,895 residents, with the impoverished northern part of the City losing more than 20 percent of its residents by 2000 (US Census Bureau, 2010b). The same estimates indicate that African Americans are approximately 49.8

percent of the population; Whites, 44.1 percent of the population, with Asians and American Indians making up, respectively, 2.7 percent and 0.20 percent (all "race alone" figures) of the city's population, with the remaining residents indicating that they were some other race or two or more races (US Census Bureau, 2010b).

Estimates of Hispanic residents indicate a population that is 3.6 percent of the population (any race) (US Census Bureau, 2010b) compared to 3.1 percent of the population in 2006 (MICA, 2010a). However, the geographic migration of racial and ethnic minority populations within the city and the slight increases in diversity have not changed the high concentration of poverty noted in the city and its attendant health concerns. This Midwestern city, with a large, poor African American population provides an illustration of the social factors associated with health disparities in cities across the United States. Colin Gordon provides an apt description of these conditions:

> This general condition, in St. Louis and elsewhere, is the seemingly iron law of urban decay: Rising incomes breed suburbanization. Suburbanization robs inner cities of their tax base. Inner city concentrations of poverty widen gaps between urban residents and substantive economic opportunities, and between suburban residents and urban concerns. And all of this encourages more flight, not only from the metropolitan core, but from decaying inner suburbs as well. (Gordon, 2008, p. 8)

It is this concentration of poverty and lack of resources that contributes to the differential exposures discussed as factors in health inequality by LaVeist (2005).

Many aspects of the psychosocial environment can affect health and health behaviors (Adler & Page, 2008). These issues can include a lack of information or the skills to manage a chronic disease or sustain a healthy lifestyle, lack of work or inadequate work or financial resources to acquire needed medication and treatment, and transportation difficulties that along with the issues previously mentioned affect patient ability to comply with treatment requests.

Protection from accident and injury may be related to the quality of the neighborhood infrastructure and the adequacy of childcare for the children of working mothers. Therefore, the socio-economic and overall psychosocial environment of St. Louis are described to provide a framework for understanding the current health status of its poorest residents.

ECONOMICS

Inequality in physical health begins in early childhood and is linked to social determinants (Chen, Matthews, & Boyce, 2002). Poverty, often associated with health inequality (Murray et al., 2006), is unrelenting in the northern portions of St. Louis City. Data suggest that it exerts an influence on the lives of African American children from birth and that its negative impacts persist throughout adolescence and into adulthood.

Figure 21.2. Loss of Small Business Enterprise, North St. Louis City.

The Census reports the 2008 median household income for St. Louis as $33,652 compared to $46,262 for the state (US Census Bureau, 2010b). Unemployment is associated with increased social isolation, feelings of powerlessness and worthlessness, and decreased self-esteem (Dahlgren & Whitehead, 1991). Unemployment in St. Louis, which was as low as 7.0 percent in 2006 (lower than previous years but 1.5 times the unemployment rate of Missouri and the US (St. Louis City Health Department, 2007), skyrocketed to 12.8 percent in 2009 and is currently 10.7 percent (Missouri Economic Research and Information Center, 2011). However, it is important to understand the City's racial disparities in socioeconomic indicators.

The percentage of households living below the poverty level is highest in the largely African American northern portion of St. Louis, which also has the highest unemployment rates (St. Louis City Health Department, 2007). Births to unmarried women and girls remain high in the City of St. Louis, with 67 percent of births occurring among unmarried women, a rate 1.8 times the Missouri rate of 36.4 percent. The St. Louis African American average rate for 2004 through 2008 (87.1 percent) was 2.5 times the St. Louis City White average rate (34 percent) and 1.11 times the average rate for African Americans in Missouri (78 percent) (MICA, 2010a). According to Kids Count (2010) data, the percentage of St. Louis City children living in single parent families increased by a little more than 5 percent from 2007 to 2009. The percentage of female headed households in St Louis was 55 percent higher than the percent observed in Missouri (St. Louis City Health Department, 2007). The ZIP codes of greatest concern are all in poorer, northern portions of the city of St. Louis. In addition, these ZIP codes also had the highest percentage of households living in poverty.

Teen mothers are less likely to complete their education, and children born to mothers without a high school diploma are more likely to live in poverty and experience negative educational, health, and mental health outcomes. Births to mothers without a high school diploma decreased between 2004 and 2008, from 29 percent to 26 percent (Kids Count, 2010). However, the percentage of African American mothers who completed less than twelve years of education (30 percent) was almost two times the rate of White mothers (16 percent) in St. Louis in 2008 (MICA, 2010b).

Access to adequate nutrition during pregnancy is important to a child's birth and development. WIC and Food Stamp participation increase the probability of adequate nutrition; however, such participation is also an indication of poverty in the community. In 2009, 52.3 percent of all births in St. Louis City were to mothers participating in WIC, and 45.71 percent were to mothers participating in the Food Stamp Program (Kids Count, 2010). Again, participation was higher among African Americans living within city limits. While the number of children in St. Louis receiving food stamps in 2008 (58.9 percent) decreased from the rate observed in 2002 (60.6 percent) (Kids Count, 2010), the pattern of disadvantage among poor African American populations living in northern portions of the city persisted.

EDUCATION

The St. Louis City Public Schools system was unaccredited in 1998. As a result of the Desegregation Case Settlement, the District was awarded a provisional accreditation. However, the district was again declared unaccredited on June 15, 2007, and is now under state supervision by a Special Administrative Board (Gay, 2007). In this environment the educational status of those students who do graduate are of grave concern. North city ZIP codes had the lowest rate of those twenty-five years old or older who had graduated high school; as many as 60.0 percent of adults twenty-five years old or older had not graduated high school in some areas of this region of the city. One ZIP code in the increasingly African American southern portion of the city shared a similar statistic (61.6 percent) (St. Louis City Health Department, 2007). Data compiled by Kids Count (2010) indicates that the annual high school dropout rate in the City of St. Louis for 2008 almost tripled since 2002 (7.8 percent to 22.2 percent). While the actual increase is likely the result of reporting changes, the dropout rate represents another negative health indicator, as it likely results in lower health literacy in the population.

Further endangering the educational status of St. Louis youth is access to quality daycare and quality after-school programs. The Mayor's Commission on Children, Youth and Families (2009) estimated that as many as one-third of the city's daycare centers were unlicensed. This would mean that less than 10 percent of children ages five to thirteen in St. Louis City had access to daily quality after-school programs, whereas the national average is 22 percent (Mayor's Commission on Children, Youth and Families, 2009).

Parent educators in the city of St. Louis serve families in very high-need neighborhoods. For various reasons, these families are reluctant to allow parent educators into their homes. Less than 20 percent of the eligible families in St. Louis participate in Parents as Teachers compared to rates as high as 75 percent in other areas of the St. Louis Metropolitan Area (Mayor's Commission on Children, Youth and Families, 2009). The reluctance of St. Louis families, largely African American and poor, to participate in PAT raises doubts about this educational strategy's viability as a resource or strategy to address the socio-economic issues that lead to poor health behaviors and outcomes.

ENVIRONMENT

LaVeist (2005) noted the deleterious effects of differential exposure to toxins for racial/ethnic minority health. According to the St. Louis City Health Department (2007), vacant lots increase sanitation and vector problems. In 2006, there were an estimated 17,145 vacant lots in the City. Lead poisoning in children is known to disrupt brain development, stunt growth, alter behavior, and damage almost every organ in the body (American Academy of Pediatrics Committee on Environmental

Health, 1993). Approximately 90 percent of the city's housing was built before 1978, and more than 60 percent was built before 1950 (http://stlouis.missouri.org/leadsafe). Lead paint, the principal source of lead exposure for St. Louis children, was used in home construction until 1978 when it was banned (http://stlouis.missouri.org/leadsafe). All of St. Louis City has been designated high risk by the Missouri Department of Health and Senior Services for lead paint exposure. In 2009, the ZIP codes with the highest rates of childhood lead poisoning were located in the northern region of the City, while one was in the southeast quadrant (City of St. Louis, 2009). However, a strategy of prevention rather than treatment has resulted in a decline in lead poisoning in St. Louis City. The rates decreased from 16.2 percent of tested children in 2001 to 3.2 percent in 2009, with 483 children reported as having elevated lead levels ≥10 ug/dl. Despite these improvements, the five ZIP codes with the highest rates of childhood lead poisoning were located in the northern region of the city (City of St. Louis, 2009). In addition, universal screening still remains a problem. Less than half of City children under six years of age were screened for lead poisoning in 2009, which is an issue because guidelines call for universal testing for children through age six due to the entire City of St. Louis being designated "high-risk" (City of St. Louis, 2009).

Over the eight years that the Asthma and Allergy Foundation of America has ranked metropolitan areas, the St. Louis region has been among the top nine seven times, with its highest ranking of first in 2009 and a current ranking of seven (Asthma and Allergy Foundation of America, 2012). However, significant disparities exist in the effect of St. Louis' issues with asthma control. The average rate of emergency room visits for asthma (2005–2009) among African Americans in St. Louis was 20.1 per 1,000, which is more than six times the rate of White St. Louis residents (3.1) (MICA, 2010a). In 2008, African American children accounted for 91.9 percent of all childhood asthma emergency room visits in St. Louis City, with an African American childhood asthma emergency room visit rate of 37.5 per 1,000, which was nine times higher than the White rate of 4.2 per 1,000 in St. Louis City in 2008 (Missouri Department of Health and Senior Services, 2009).

Crime has a negative effect on children's environments due to its impact on injury rates, mental health, and development. High crime rates affect the ability of parents to limit children's exposure to violence and provide safe places for them to play. The homicide rate for African Americans is consistently significantly higher than for Whites. For example, between 1999 and 2009 the average death rate from assault among African Americans in St. Louis City was 51.7 per 100,000 versus a rate of 5.7 for Whites (MICA, 2010a). The average homicide rate among African Americans in St. Louis City was 51.73 per 100,000 versus a rate of 5.72 for Whites (MICA, 2010a). Homicide rates saw a dip in 2003 but otherwise remained at the rate of 25 to 30 per 100,000 with a slight increase in 2008 to a rate of almost 36 per 100,000 (MICA, 2010a). The highest homicide rates were observed in ZIP codes that also experience high levels of poverty and poorer educational outcomes (St. Louis City Health Department, 2007).

ACCESS TO HEALTHCARE

Access to healthcare can be an important marker for health outcomes. As Hunter and Killoran have noted, "Where the need is greatest, there is often the poorest supply or quality of provision" (2004, p. 14). This is nowhere more evident than in St. Louis.

Medicaid eligibility is positive in that it indicates that there is coverage for healthcare; it is negative because it indicates significant poverty in a community. African Americans in St. Louis City are more likely than Whites to receive Medicaid. Medicaid eligibility during pregnancy is 180 percent of the federal poverty level. In 2008, 3,310 of 5,419 births (61.0 percent) were to mothers who were Medicaid participants (MICA, 2010b). The number of St. Louis City children enrolled in MC+ (Missouri's health insurance program for children under the age of nineteen, some parents, and pregnant women) and Medicaid has declined from 75.1 percent in 2002 to 56.3 percent in 2008 (Kids Count, 2010). In 2005, the highest Medicaid eligibility rates were in ZIP codes that have primarily African American populations, while the lowest were in ZIP codes that have predominantly White residents (St. Louis City Health Department, 2007).

According to the Missouri Department of Health & Senior Services birth data, 83.8 percent of St. Louis City mothers received adequate prenatal care in 2009 (MICA, 2010b). Of 5,121 births, 709 pregnant women did not receive first trimester prenatal care in St. Louis City. Of those 709, 116 received no prenatal care. The rate of inadequate prenatal care is 3.8 times greater for African Americans than Whites in St. Louis City (MICA, 2010b). The ZIP codes of greatest concern were again in the northern corridor of the City (St. Louis City Health Department, 2007). While there are Federally Qualified Health Centers (FQHCs) in North St. Louis City providing primary care, there is an absence of primary care physicians (St. Louis City Health Department, 2007). The dearth of primary care physicians likely contributes to rates on inadequate prenatal care.

When unnecessary visits to the emergency room are examined, healthcare quality issues are highlighted. Tables 21.2 and 21.3 illustrate the point. In each instance,

Table 21.2. Emergency Room: Residents of St. Louis City

Diagnosis: Diabetes			
	Year 2009		
Race	*Number of Visits*	*Rate*	*Confidence Interval*
White	167	0.9	0.8 to 0.10
Black/African American	810	4.9	4.6 to 5.3
All Races	1,006	2.8	2.6 to 3.0

Rates per 1,000
Age Adjustment Uses 2000 Standard Population
Confidence Interval for Rates by the Inverse Gamma Method, 95 percent confidence interval
Source: MICA, http://health.mo.gov/data/mica/mica/er.php

Table 21.3. Emergency Room Visits: Residents of St. Louis City

Diagnosis: Hypertension			
	Year 2009		
Race	*Number of Visits*	*Rate*	*Confidence Interval*
White	155	0.9	0.7 to 1.0
Black/African American	1,095	6.8	6.4 to 7.2
All Races	1,275	3.6	3.4 to 3.8

Rates per 1,000
Age Adjustment Uses 2000 Standard Population
Confidence Interval for Rates by the Inverse Gamma Method, 95 percent confidence interval
Source: MICA, http://health.mo.gov/data/mica/mica/er.php

diseases (diabetes and hypertension) that can be managed on an outpatient basis more often result in emergency room care for African Americans in St. Louis.

HEALTH OUTCOMES

Table 21.4 paints a bleak picture, although not unexpected, of the health status of African American residents of St. Louis City. The only disease with a lower rate among African Americans compared to White residents of the city is for chronic obstructive pulmonary disease. Table 21.5, which provides the all-cause mortality rate for the city, provides further confirmation of the health disparities encountered among African Americans.

Infant health is a sensitive indicator of the overall health of a community. Low birth weight, infant mortality, and child death occur at higher rates in St. Louis City than in the general Missouri population. As child health indicators have improved, the disparities between St. Louis City and the state remain (table 21.6). The St. Louis African American rate of 16.4 infant deaths per 1,000 live births (1997–2007) was 2.9 times the White rate of 5.7 infant deaths per 1,000 live births. A profile of infant health by race appears in table 21.7. These data dramatically illustrate that African Americans in the city of St. Louis are born at a significant disadvantage with respect to health.

People are able to live happy, functional, and contributing lives within the context of communities that have access to and a sense of control over a portion of the social determinants of health and well-being. These determinants consist minimally of access to conditions, institutions, systems and resources that influence well-being, including: nutrition (supermarkets, groceries, etc.), individual health resources (clinics, hospitals, etc.), skill/intellectual development (schools, libraries), the physical environment (housing, parks, safe streets and communities), economic resources (opportunities for jobs, commerce and capital accumulation), and social institutions (governance, neighborhood, faith and family). These social ecological factors are de-

Table 21.4. Chronic Disease—Deaths: Residents of St. Louis City, 2009.

	Race								
	White			*Black/African American*			*All Races*		
Cause of Death	*Number*	*Rate*	*Confidence Interval*	*Number*	*Rate*	*Confidence Interval*	*Number*	*Rate*	*Confidence Interval*
Cerebrovascular disease (stroke)	65	30.8	23.5 to 39.7	77	48.4	38.0 to 60.6	145	39.1	32.8 to 46.1
Chronic obstructive pulmonary disease (COPD)	81	45.6	35.9 to 57.2	47	29.6	21.7 to 39.5	128	37.2	30.9 to 44.3
Diabetes	32	17.4	11.7 to 25.0	68	43.0	33.3 to 54.8	100	28.9	23.4 to 35.3
Heart disease	417	210.6	190.0 to 232.9	379	240.8	216.9 to 266.5	801	222.6	207.1 to 238.9
Kidney disease (nephritis/nephrotic syndrome/nephrosis)	20	9.3	5.4 to 14.8	39	24.9	17.6 to 34.2	59	16.7	12.6 to 21.6

Rates are per 100,000
Age adjustment uses year 2000 standard population
Confidence interval for rates by the Inverse Gamma Method, 95 percent confidence interval
@ Rate considered unreliable, numerator less than 20
Source: MICA, http://health.mo.gov/data/mica/mica/chronic_death.php?

Table 21.5. Deaths: Residents of St. Louis City, 2009

Cause of Death = All Causes			
Race	*Number*	*Rate*	*Confidence Interval*
White	1,508	790.9	750.0 to 833.6
Black/African American	1,547	956.8	909.2 to 1,006.3
All Races	3,081	861.3	830.6 to 892.9

Rates are per 100,000
Age adjustment uses 2000 standard population
Confidence Interval for rates by the Inverse Gamma Method, 95 percent confidence interval
Source: MICA, http://health.mo.gov/data/mica/mica/death.php

Table 21.6. Reported Cases of Low Birth Weight and Infant and Child Mortality in Years 1999–2003 and 2004–2008

	St. Louis City		*Missouri*	
	2004–2008	*1999–2003*	*2004–2008*	*1999–2003*
Low Birth Weight Infants	11.8%	11.8%	8.1%	7.8%
Infant Mortality (per 1,000 live births)	10.6	13.3	7.4	7.7
Child Deaths Ages 1–14 (per 100,000)	23.8	36	20.3	24.2

Kids Count Data Center (2010). http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?

picted in figure 21.3, which depicts the relationship between determinants of health and African American well-being.

CONCLUSION

The distribution of the aforementioned factors among population groups varies significantly. The St. Louis City case illustrates not only racial disparities in income, but striking disparities in the concentration of poverty within the city limits. These disparities exist across the major social determinants. For example, the largely African American St. Louis City Public Schools system was unaccredited in 1998 and, while awarded a provisional accreditation, was again declared unaccredited June 15, 2007, and is now under state supervision by a Special Administrative Board. This single event strikes a startling blow to the community sense of control.

In this environment, social capital, critical to the development of other community resources, can wane. Social capital is a multidimensional construct that is associated with positive psychological and health outcomes (Almedon, 2005; Sampson, Morenoff, & Gannon-Rowley, 2002). It encompasses social relationships among community members, a sense of community cohesion, and the ability to exert control within the community. Those living in areas with higher levels of collective efficacy

Table 21.7. Infant Health Profile for St. Louis City Residents by Race

		White		*Black*		*White*	*Black*
	Data Year(s)	*# of Events*	*Rate*	*# of Events*	*Rate*	*State Rate*	*State Rate*
Preterm Births (less than 37 Weeks Gestation)	2005–2009	1262	13.37	3495	22.08	11.85	19.27
Low Birth Weight	2005–2009	731	7.74	2316	14.63	7.02	13.78
Low Birth Weight and Term	2005–2009	206	2.52	660	5.35	2.53	5.25
Very Low Birth Weight	2005–2009	142	1.5	503	3.18	1.21	3.18
Small for Gestational Age	2005–2009	674	7.44	2274	14.97	7.96	14.9
Infants on Medicaid	2009–2009	683	34.22	2755	94.41	45.01	81.07
Neonatal Deaths per 1,000	1999–2009	80	3.91	387	10.86	3.99	10.47
Perinatal Deaths per 1,000	1999–2009	190	9.23	857	23.74	8.79	21.56
Post Neonatal Deaths per 1,000	1999–2009	28	1.37	188	5.28	2.18	5.18
Infant Deaths per 1,000	1999–2009	108	5.27	575	16.14	6.17	15.64

Source: MICA, http://health.mo.gov/data/mica/ASPsInfant/header.php?cnty=191#

Figure 21.3. Community Determinants of Well-Being.

and sense of community and informal control have lower rates of violence and more promising education and social outcomes among youth. The efficacy required to rebuild community is limited when individuals and communities experience the psychological and social reality of communities like St. Louis. Similarly, elements of social capital (trust, reciprocity, and community engagement) are associated with lower rates of mortality due to multiple diseases including cardiovascular disease and cancer (Sampson, Raudenbusch, & Earls, 1997). In addition, social capital may serve as a buffer against the deleterious effects of personal risk factors (Evans & Kutcher, 2010). Because of the importance of collective efficacy and social capital, it is disturbing how little we know about re-building these resources in communities where the sense of efficacy is diminished and hope is all but eliminated.

In order to begin the process of rebuilding social capital and efficacy, connections to resources and networks outside of what one defines as the personal, physical or psychological community or neighborhood are likely required. A community may have strong internal ties and networks but weak social capital in the larger, better resourced

majority community. The capacity to draw on external resources is considered particularly important when attempting to develop economic opportunities (Helmsing, 2003) and seems relevant to the North St. Louis situation. It is, therefore, essential to develop partnerships between community members and representatives from government, academia, and business that have internal trust and capacity and can bring outside resources and skills into communities. However, when history dictates that these relationships are virtually non-existent, are we to abandon communities?

An ecological approach and community-based participatory principles have been proposed to address these issues. However, these frameworks are more likely to result in progress in communities that already possess social capital. For communities like North St. Louis, we must now focus our attention on developing interventions that re-knit communities and prepare them for integrated, economic, educational, and health interventions that influence change at the individual, social, and community levels. This requires sustained efforts to re-establish meaningful dialogue between members of the community and leaders of the institutions best positioned to address their fears, concerns and needs.

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22

Flint Adolescent Study

A Longitudinal Examination of Social Support and Achievement Motivational Beliefs of African American Adolescents

Sheretta T. Butler-Barnes, Noelle Hurd, and Marc A. Zimmerman

This chapter focuses on the micro- and meso-level experiences of academically at-risk African American adolescents in a distressed urban inner city. The purpose of this chapter is to highlight the academic achievement issues of African American adolescents within Flint, Michigan. Flint is a city with a declining resident population and economic issues (e.g., school closures and job loss), and these problems most often trickle down to the educational system. For instance, between 1990 and 2000, Flint city had one of the largest losses of students within the school district, and 77 percent are economically disadvantaged (Erickcek, 2007; Menchik, 2002; U.S. Census Bureau, 2010). Additionally, in 2005 and 2006, 26 percent and 27 percent of Flint city students met or exceeded standards in core content areas (i.e., mathematics), respectively (Erickcek, 2007). The educational statistics are especially dismal when exploring the intersection of race/ethnicity, social class, and being at-risk for school failure. For instance, African American adolescents in the current study had the lowest grade point averages in comparison to their non-Black peers. Thus, the goal of the study reported in this chapter is to address the gaps in the research literature on the benefits of social support among academically at-risk African American adolescents. Building upon solid empirical literature, we seek to fill the gaps in three ways: 1) exploring African American adolescents' contextual-level social support systems within an economically distressed city, 2) using a person-oriented approach to understand the variation in African American adolescents' contextual-level support systems, and 3) understanding how contextual-level social support systems impact achievement motivation beliefs over time.

Social Support and Academic Achievement

The literature on African American adolescent achievement underscores the importance of social support in facilitating positive academic outcomes (Bean, Bush, McKenry, & Wilson, 2003; Epstein, 2001; Henderson & Mapp, 2002). More specifically, access to social support is predictive of higher endorsements of positive future education orientation, higher reports of intention to complete high school, better school attendance, and achievement motivational beliefs (e.g., Davis, Johnson, Miller-Cribbs, & Saunders, 2002; Davis-Maye & Perry, 2007; Kerpelman, Eryigit, & Stephens, 2008; Nebbitt, 2009; Plybon, Edwards, Butler, Belgrave, & Allison, 2003; Richman, Rosenfeld, & Bowen, 1998; Steward, Steward, Blair, Jo, & Hill, 2008). For instance, Kenny and colleagues (2007) conducted a qualitative examination of perceived barriers to educational success among African American and Latino high school students and found that positive support from parents and peers were concerns for adolescents in both low- and high-achieving groups. Thus, similar to high-achieving students, low-achieving students identified positive support as being crucial for academic success, despite their low-achieving status.

Adolescence is characterized by changes in social, cognitive, and psychological development (e.g., physical maturity and increases in cognitive awareness) (Blakemore, 2008; Gestsdóttir & Lerner, 2008; Lenroot & Giedd, 2010; Waber, Mann, Merola, & Moylan, 1985). Establishing and maintaining positive relationships becomes central during this developmental stage. The research literature underscores the unique contributions of maternal and peer support to achievement and academic adjustment among African American adolescents. In light of this documented association, we seek to gain additional insight into how various social support mechanisms (e.g., father support) influence the academic self-efficacy beliefs of African American adolescents utilizing a person-oriented approach. This approach allows for the examination of social support patterns and the exploration of the variation in identified patterns.

With regards to peers, the early formation of supportive peer relationships may also promote school relevant competencies and serve as a protective factor for African American children and adolescents (Campbell, Pungello, & Miller-Johnson, 2002; Gonzales, Cauce, Friedman, & Mason, 1996), such that peer support and belonging has been associated with positive adjustment (Van Ryzin, Gravely, & Roseth, 2009), achievement, and pro-social behavior (Gonzales et al., 1996; Wentzel, 1998). Yet some researchers have found no relationship or a negative association between peer support and achievement outcomes (e.g., Fordham & Ogbu, 1986). These inconsistencies in the research literature highlight the importance of exploring the type of peer support (e.g., emotional) associated with positive academic outcomes of minority students and the methodology used to assess peer support. Thus, collectively identifying patterns of perceived social support is warranted to contribute to the current literature on how these contextual-level resources influence achievement motivational beliefs. Moreover, different social support structures (e.g., parents and/or peers) can serve as a risk and/or resource depending on the contextual setting (Spencer, Cole, DuPree, Glymph, & Pierre, 1993).

Additionally, despite the evidence that various sources of social support may or may not contribute to African American adolescents' academic outcomes, to our knowledge this is the first study to examine contextual-level sources of perceived social support (i.e., mother, father, and peer) that may promote the academic self-efficacy beliefs of African American adolescents.

Self-Efficacy Beliefs & Academic Achievement

Self-efficacy beliefs are the foundation of human agency and involve the extent an individual believes they can pursue and accomplish a goal (Bandura, 2001). Positive outcomes come from students' efforts and hard work exerted to pursue goals (e.g., persistence on an academic task). Studies suggest that stronger self-efficacy beliefs lead to higher self-pride and motivational engagement in academic tasks (Pajares, 2003; Zimmerman, Bandura, & Martinez-Pons, 1992), better academic performance (Bandura et al., 1996), academic aspirations (Carroll et al., 2009) and higher GPA over time (Majer, 2009). High academic efficacy also indirectly predicts academic performance outcomes through its influence on social functioning and well-being (Bandura, Barbaranelli, Caprara, & Pastorelli, 2001).

Self-efficacy beliefs are developed and altered by four components: mastery experiences, vicarious learning, verbal persuasion, and physiological states. Mastery experiences involve acquiring a subset of skills for effectively executing and creating plans throughout the developmental lifespan. The social models (e.g., peers) in the environment provide vicarious learning experiences. In the academic context, adolescents observe students of varying academic abilities succeed or fail (Bandura, 1986, 2001; Schunk, 1987). Verbal persuasion can promote or hinder self-efficacy beliefs based on positive or negative feedback. If students' social environments include persons who provide positive feedback, the student will likely exert more effort, whereas negative feedback may decrease self-efficacy beliefs. Lastly, a student's physiological state can determine the type of activities a student pursues. For instance, adolescents may experience anxiety or psychological distress that may prevent engagement in academic tasks, despite their intellectual capacity.

In summary, all four components of efficacy belief development are pertinent; however, the area of focus for the current study is verbal persuasion. In this study, verbal persuasion is defined as the variation in the quantity and/or quality of perceived emotional support from parents or peers. Feedback at the contextual-level may involve receiving support from parents and peers that involves moral support and problem-solving interactions at the meso-level (e.g., home and school). This may involve negative feedback, regardless of student's academic motivational beliefs. Thus, if African American adolescents consistently perceive low to no support from parents and peers around them, this may decrease motivational effort. Thus, the focus is on the prevalence of perceived social support systems among academically at-risk African American adolescents. For instance, to what extent does perceived social support from parents and peers influence achievement motivation among at-risk adolescents?

Additionally, coupled with the situational context of a struggling urban inner city, identification of social support systems is crucial. Yet despite these risk factors, there are adolescents who thrive and are resilient. If this is the case, it is important to identify adolescents with varying levels of supportive parents and peers and who perform academically well.

There is also a dearth of research literature examining the self-efficacy beliefs of African American adolescents. For instance, the plethora of studies examining the relation of self-efficacy beliefs and academic achievement most often did not mention race or ethnicity (e.g., Bandura et al., 1996, 2001; Bouffard-Bouchard, Parent, & Larivee, 1991; Jackson, 2002; Multon, Brown, & Lent, 1991; Pajares, 1996; Pajares & Valiante, 1997). Additionally, studies of achievement motivation tend to be race comparative (Graham, 1994). In a review of achievement motivation studies with African American samples, Graham (1994) noted that 77 percent were race comparative, thus not allowing examination of within-group variation in beliefs. Furthermore, while the studies reviewed examined other motivational attributes—the need for achievement, locus of control, attribution, expectancy beliefs, and self-concept—none of the studies included in Graham's review actually examined African Americans' self-efficacy beliefs. The present study will address the gaps in the literature by exploring the self-efficacy beliefs of African American adolescents. Additionally, self-efficacy beliefs have not been explored as a possible explanation for the current academic performance of African American adolescents. Because self-esteem and self-concept remain relatively high, despite academic performance, other self-constructs have to be explored, especially in addressing the complexities of African Americans' beliefs and school achievement. For instance, Schunk and Pajares (2003) found that self-efficacy is a better predictor of achievement than self-concept and self-esteem, underscoring why self-efficacy should be examined among African American children and adolescents.

Guiding Framework

The current study draws on a developmental assets framework (e.g., Benson, 2003; Lerner, 2003; Sesma, Mannes, & Scales, 2005). The premise is that despite being academically at-risk for school failure, it is important to identify social support systems that contribute to positive achievement motivational beliefs. From a strength-based perspective, parents and peers play a vital role in the lives of African American adolescents' attitudes and beliefs. Since it is still unclear how these social support systems collectively influence motivation, we were interested in how contextual-level support resources (e.g., mother, father, and peer support) promote academic self-efficacy beliefs over time.

Study Aims

The aim of this study is to examine the collective role of contextual-level social support systems (i.e., mother, father, and peer) by utilizing a person-oriented ap-

proach. For instance, is it high levels of mother, father, and peer support that predict higher achievement motivation beliefs? Or perhaps, higher mother and father support? Additionally, as peers become increasingly important during adolescence, are higher levels of peer support and lower levels of mother and father support associated with higher achievement motivation beliefs? The study is methodologically innovative in its aim to use a person-oriented approach to identify classes of perceived social support systems among African American adolescents. The goal is to understand how social support systems influence achievement motivation beliefs by: 1) using latent class regression to assess the number of classes, and 2) understanding the association between classes of perceived social support and academic self-efficacy beliefs over time. Additionally, to our knowledge, this is the first study to utilize latent class regression analysis to examine various social support systems among an academically at-risk sample of African American adolescents (see figure 22.1).

METHOD

Participants

The sample for this study included 403 African American adolescents drawn from the Flint Adolescent Study (FAS), an ongoing longitudinal study examining factors that reduce school dropout and academic failure. The inclusion criteria for participating in the study was that students would be incoming high school freshman in the 1994–1995 academic calendar year and have a grade point average (GPA) of 3.0 or below in the previous year (8th grade). At wave one, 850 students, 679 (80 percent) African American, 145 (17 percent) White, and 26 (3 percent) mixed race (Black and White) adolescents participated in the study.

Due to the importance of perceived social support and academic self-efficacy beliefs of African American adolescents, students who identified as African American

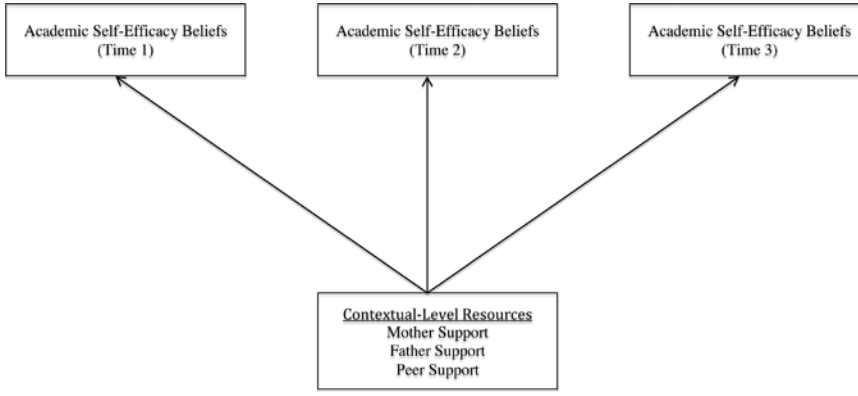

Figure 22.1. Proposed Conceptual Model.

and who had complete data on all primary study variables were selected from wave two (N=568, 1995–1996 school year), wave three (N=507, school year 1996–1997), and wave four (N=455, school year 1997–1998), therefore, our final sample was N=403 (48 percent boys and 52 percent girls). The final sample included adolescents who had complete data from waves two to four. T-test results revealed that adolescents included in the study were younger (M=17.67, SD=.55), $t(406)=-2.879$, $p<.05$), had higher GPA (M=1.69, SD=.97), $t(406)=2.603$, $p<.10$), had higher father support (M=3.51, SD=1.21), $t(406)=9.643$, $p<.001$), and had higher mother support (M=4.15, SD=.85), $t(406)=2.086$, $p<.05$). For additional study information, see http://www.sph.umich.edu/prc/projects/fas/index.html.

Measures

The variables included in wave two were as follows: adolescent gender, highest socioeconomic status, academic importance, mother support, father support and peer support. Variables included in waves two, three, and four were the outcome variable (academic self-efficacy beliefs), adolescent age, and GPA.

The Academic Self-Efficacy Beliefs and the Academic Importance Scales have been used in previous studies (e.g., Bryant & Zimmerman, 2002).

Academic Self-Efficacy Beliefs Scale. Adolescents' academic self-efficacy beliefs were used to assess adolescents' achievement motivation beliefs. Academic Self-Efficacy Beliefs (Roeser, Lord, & Eccles, 1994) were measured using five items (e.g., "*I can do even the hardest school work if I try*"). The response scale ranged from 1 = not true to 5 = very true. Cronbach's alpha for waves two, three, and four were .80, .83, and .86, respectively.

Academic Importance Scale. Adolescents' academic importance beliefs were used to assess adolescents' belief about the importance of school. The scale included four items (e.g., "*Going to school will help me reach my goals*") Reponses for both scales ranged from 1 = not true to 5 = very true. Cronbach's alpha is .79.

Peer Emotional Support. Adolescents' perceptions of perceived peer support were assessed with a support scale based on adolescents' feelings and experiences with their peers used in the FAS study. Five items were used and adolescents responded to how true the statement was using a 5-point scale, 1 = not true to 5 = very true (e.g., "*I rely on my friends for emotional support*"). Cronbach's alpha for this scale is .87.

Mothers' Emotional Support. Adolescents' perceived social support was examined using the parental support scale (Procidano & Heller, 1983). Five items were used to assess mother support. Adolescents responded regarding how true each of the statements were using a 5-point scale, 1 = not true to 5 = very true (e.g., *"My [mother] enjoys hearing what I think about"* and *"I rely on my [mother] for emotional support").* Cronbach's alpha for this scale is .88.

Fathers' Emotional Support. Adolescents' perceived social support was examined using the parental support scale (Procidano & Heller, 1983). Five items were used to assess father support. Adolescents responded regarding how true each of the state-

ments were using a 5-point scale, 1 = not true to 5 = very true (e.g., *"My [father] enjoys hearing what I think about"* and *"I rely on my [father] for emotional support*"). Cronbach's alpha for this scale is .94.

Demographic background and control variables. Demographic background variables in the study included adolescents reported age, sex (1 = boy and 2 = girl), grade performance (final end-of-the-year grade point average (GPA) for the current academic year), and academic importance beliefs. Family socioeconomic status (SES) variable was based on prestige scores of reported parents' occupations (Nakao & Treas, 1990).

RESULTS

Descriptive and Correlational Analyses

The means and standard deviations for the primary study variables are presented in table 22.1. The typical parent had a service occupation (M=40.68, SD=10.99). Generally, adolescents reported high academic self-efficacy beliefs in wave two (M=4.15, SD=.45), wave three (M=4.60, SD=.52) and wave four (M=4.54, SD=.57). Adolescents also had high academic importance beliefs (M=4.73, SD=.46). Adolescents also reported high mother support (M=4.14, SD=.85) and moderate levels of father support (M=3.51, SD=1.21) and peer support (M=3.33, SD=.94). On average youth reported having a C- to D grade point average; girls had higher GPAs in wave three (M=1.73, SD=.99) $t(406)=-2.253$, $p<.05$ and wave four (M=2.24, SD=.63), $t(406)=-3.417$, $p<.001$. Girls also reported higher peer support (M=3.61, SD=.89), $t(406)=-5.075$, $p<.001$ relative to boys (M=3.15, SD=.94). With regards to mother and father perceived social support, boys reported higher mother support (M=4.20, SD=.78), $t(406)=2.12$, $p<.05$ relative to girls

Table 22.1. Primary and Background Study Variable Means and Standard Deviations

	Wave 2		*Wave 3*		*Wave 4*	
	M	*SD*	*M*	*SD*	*M*	*SD*
Academic Self-Efficacy	4.15	.45	4.60	.52	4.54	.57
Academic Importance	4.73	.46				
Mother Support	4.14	.85				
Father Support	3.51	1.21				
Peer Support	3.33	.94				
Highest SES	40.68	10.99	-------	-------	-------	-------
Average GPA	1.70	.92	1.69	.98	2.14	.65
Age	15.73	.54	16.70	.55	17.67	.55

Note. The mean and standard deviations for waves 2 to 4 are based on the sample before cluster classification. Average grade is defined as 1=D or below, 2=C−, 3=C, 4=C+, 5=B−, 6=B, 7=B+, 8=A−, 9=A.

(M=4.00, SD=1.02) and higher father support (M=3.47, SD=1.32), $t(406)$=4.005, p<.001 relative to girls (M=2.94, SD=1.34).

Correlational analyses indicated that perceived mother support was significantly positively associated with academic self-efficacy beliefs at wave two (r=.22, p<.01), wave three (r=.28, p<.01), and wave four (r=.29, p<.05). Father support was also significantly positively associated with academic self-efficacy beliefs at wave two (r=.14, p<.05), wave three (r=.16, p<.01), and wave four (r=.14, p<.05). Lastly, peer support was significantly positively associated with academic self-efficacy beliefs at wave two (r=.16, p<.01) (see table 22.2).

Latent class regression analysis was implemented using Latent Gold 4.5 (Magidson & Vermunt, 2004). Latent class regression analysis combines cluster analysis and regression analysis into a single analysis. We used latent class regression to identify clusters based on African American adolescents who share similar levels of mother, father, and peer support. Adolescents who are classified into a single cluster are similar to those adolescents in the cluster on the predictor (i.e., mother, father, and peer support) and the dependent variable (i.e., academic self-efficacy beliefs). Several empirical studies have utilized latent class regression analytic technique (e.g., Bouwmeester, Sijtsma, & Vermunt, 2004; Van Horn et al. 2009; Wong & Maffini, 2011). Additionally, there have been an increasing number of empirical studies that have utilized a person-oriented approach to explore various academic and psychosocial adjustment outcomes of African American adolescents (e.g., Chavous et al. 2003; Neblett et al. 2008). The benefits of utilizing latent class regression analysis as opposed to a traditional regression model are 1) rather than assuming our sample of adolescents belong to one population, latent class regression relaxes this assumption, and 2) traditional regression models rely on two- and three-way interactions, thereby examining separate interaction terms. In contrast, latent class regression provides differential effects based on identified clusters of associations between perceived support clusters and academic self-efficacy beliefs.

The model fit results for the latent class regression models 1 to 5 are presented in table 22.3. The results indicated that the 2 and 3-class models were an adequate fit.

Therefore, the 2 and 3-class models were compared to assess the model improvement using a conditional bootstrap method. The difference in L^2 between the 2 and 3-class models indicates an improvement in fit associated with the 3-class model if significant. The analyses indicated that the 3-class model did provide a significant improvement over the 2-class model because of a significant bootstrap p-value (p=.001). Additionally, the 3-class model had the lowest AIC (6368.22). Thus, the 3-class model was our final solution. Class 1 to Class 3 consisted of 56 percent (N=228), 28 percent (N=114), and 15 percent (N=61) of the sample, respectively (see table 22.4).

A chi-square analysis of the three-class solution was conducted by examining if the classes differed on the demographic variables. Chi-square tests revealed that there were no significant differences by gender ($\chi^2[2]$=1.91, p=.38). With regards to grade point average and academic importance beliefs, there were significant differences across the

Table 22.2. Primary Study Variable Correlations

Variables	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*
1. Gender														
2. Highest SES	–.08													
3. 8th Grade GPA (Wave 2)	.06	.10*												
4. 9th Grade GPA (Wave 3)	.11*	.08	.62**											
5. 10th Grade GPA (Wave 4)	.17**	.05	.50**	.50**										
6. Age (Wave 2)	–.07	–.08	–.23**	–.30**	–.16*									
7. Age (Wave 3)	–.07	–.09	–.23**	–.31**	–.17*	——								
8. Age (Wave 4)	–.08	–.08	–.22**	–.28**	–.15*	——	——							
9. Academic Importance	.15**	.07	.11*	.09	.12*	.00	–.00	–.04						
10. Academic Self–Efficacy (Wave 2)	.04	.04	.01	.01	.12*	–.04	–.04	–.04	.51**					
11. Academic Self–Efficacy (Wave 3)	.00	.06	.05	.05	.09	.00	–.00	–.00	.38**	.41**				
12. Academic Self–Efficacy (Wave 4)	–.05	.04	.03	–.04	.00	–.01	–.02	–.01	.26**	.35**	.44**			
13. Mother Support	–.10*	–.01	–.09	–.04	.03	.02	.03	.02	.22**	.22**	.28**	.29**		
14. Father Support	–.20**	–.01	.06	.02	.04	.04	.03	.04	.10	.14*	.16**	.14*	.38**	
15. Peer Support	.24**	–.06	.12*	.15	.14*	–.23**	–.25**	–.23**	.15**	.16*	.08	.06	.15**	.10

Note. N=403. * p<.05, **p<.010.

Table 22.3. Model Fit Statistics for Five Latent Class Models

Model	*AIC*	L^2	L^2 *difference*
1-Class Model	6522.60	5561.31	
2-Class Model	6391.54	5406.25	
3-Class Model	6368.22	5358.93	47.32***
4-Class Model	6376.48	5343.20	
5-Class Model	6396.64	5339.34	

Note. L^2 difference refers to the difference between L^2 value for the class models and the previous model (i.e., 3-class model vs. 2-class model). ***p<.001.

Table 22.4. Group Comparisons Among Latent Classes on the Main Study Variables

Variables	*Class 1 (56%) (N=228)*	*Class 2 (28%) (N=114)*	*Class 3 (15%) (N=61)*
Mother Support	4.08	4.31	3.74
Father Support	3.10	3.52	2.88
Peer Support	3.39	3.47	3.39
Demographics			
Highest SES	40.54	40.32	38.45
GPA	2.08	2.29	1.63
Age	15.88	15.74	16.00
Academic Importance	4.95	4.61	3.88

Note. Means are presented based on latent class structure. Class 1 Peer and Father Support, Class 2 Negative Peer Support, and Class 3 Peer Support. With the exception of mother support, father support, peer support, academic importance, and highest SES, all other variables (i.e., GPA and Age) were measures at waves 2 to 4.

classes. Adolescents in class 2 had higher grade point averages and academic importance beliefs over time.

Table 22.5 displays the parameter estimates for the 3-class model. Across the three waves, mother (Wald=9.24, p<.05), father (Wald=8.52, p<.05), and peer support (Wald=16.10, p<.001) differed significantly. For adolescents in class 1 (Peer and Father Support), perceived peer and father support significantly positively predicted academic self-efficacy beliefs over time. In class 2 (Negative Peer Support), mother and father perceived social support did not significantly predict academic self-efficacy beliefs over time, yet stronger perceived peer support was associated with lower academic self-efficacy beliefs over time. Lastly, similar to class 2, mother and father perceived social support was not predictive of academic self-efficacy, however, in class 3 (Peer Support), peer support was associated with higher academic self-efficacy beliefs. Also, there were more girls (N=121) in class 1 (Peer and Father Support) in comparison to boys (N=107), more girls (N=62) in class 2 in comparison to boys (N=52), and more boys (N=37) in class 3 relative to girls (N=24). With regards to the demographic differences, adolescents in class 1 had higher academic importance beliefs (Wald=22.65, p<.001), adolescent in class 2 had higher GPA over time and

Table 22.5. Latent Class Regression Predicting Waves 2, 3, and 4 Academic Self–Efficacy Beliefs

Perceived Social Support	*Class 1 Peer & Father Support*			*Class 2 Negative Peer Support*			*Class 3 Peer Support*		
Variables	*B*	*SE*	*p–value*	*B*	*SE*	*p–value*	*B*	*SE*	*p–value*
Mother Support	.19	.12	*p*>.05	.17	.16	*p*>.05	.36	.20	*p*>.05
Father Support	.16	.07	*p*<.03*	.09	.10	*p*>.05	–.23	.13	*p*>.05
Peer Support	.32	.11	*p*<.01**	–.60	.24	*p*<.01**	.35	.18	*p*<.05*
Demographics									
Gender	–.39	.37	*p*>.05	–.22	.32	*p*>.05	.61	.53	*p*>.05
Highest SES	–.01	.01	*p*>.05	–.00	.01	*p*>.05	.01	.02	*p*>.05
GPA	.45	.32	*p*>.05	.98	.27	*p*<.001***	–1.43	.48	*p*<.01**
Age	.22	.36	*p*>.05	–.28	.27	*p*>.05	.06	.41	*p*>.05
Academic Importance	6.25	1.36	*p*<.001***	–.78	.69	*p*>.05	–5.47	1.19	*p*<.001***

Note. Highest SES was from wave 1. Mother support, father support, peer support, and academic importance were from wave 2. Academic self–efficacy beliefs are from waves 2 to 4.

adolescents in class 3 had the lowest GPA (Wald=12.61, $p<.010$) and academic importance beliefs (Wald=22.65, $p<.001$) over time.

DISCUSSION

In this study, African American adolescents were in 3 latent classes: peer and father support, negative peer support, and peer support. We also explored how these 3 latent class models would predict academic self-efficacy beliefs over time. Moreover, we contributed to the literature underscoring the importance of social support systems and positive youth development. Additionally, to our knowledge, this was the first study to use a latent class regression model, utilizing a developmental assets framework. Thus, guided by our framework we examined how perceived social support promoted achievement motivational beliefs of academically at-risk African American adolescents.

The first objective of the study was to determine an adequate model fit for the data by utilizing a latent class regression analysis. The results revealed a 3-class model. Across the 3 waves of data (waves two, three, and four), the predictor variables significantly predicted academic self-efficacy beliefs. The majority of adolescents (N=56 percent) belonged to the Peer and Father Support class, which had the highest academic self-efficacy beliefs in comparison to adolescents in class 2 (Negative Peer Support) and class 3 (Peer Support). These findings also underscore the importance of fathers' roles, such that stronger father support was predictive of higher academic self-efficacy beliefs over time. Our findings also have implications on parenting research. For instance, our findings are consistent with the literature on father involvement and achievement (Cooper, 2009; Rogers, Theule, Ryan, Adams, & Keating, 2009; Trask-Tate, Cunningham, & Lang-DeGrange, 2010). For instance, Trask-Tate et al. (2010) found that father support was predictive of lower psychological distress among African American girls. Rogers et al. (2009) found that father support and encouragement was associated with a positive sense of self.

Twenty-eight percent of the adolescents in this sample were in class 2 (Negative Peer Support). Adolescents in this group had peer support systems that were predictive of lower academic self-efficacy beliefs. These findings corroborate previous research documenting the negative impact of peers on African American adolescents' achievement motivational beliefs (e.g., Fordham & Ogbu, 1986). We speculated that African American adolescents in this class may be encountering peers who do not share similar achievement values, hence, support from these peers is not beneficial over time. It is also interesting to note that adolescents in this class had higher GPAs in comparison to adolescents in class 1 (Peer and Father Support) and class 3 (Peer Support). Adolescents' in this group might maintain a higher GPA because they believe that peer relationships are disruptive to their academic success.

Fifteen percent of adolescents were in class 3 (Peer Support). Adolescents in this group had lower scores on academic self-efficacy beliefs, academic importance be-

liefs, and GPA, yet stronger peer relationships in this class predicted higher academic self-efficacy beliefs. These findings highlight qualitatively the significant difference between class 2 and class 3. Peer support in this case appears to promote underachievement (lower academic self-efficacy beliefs). We speculate that adolescents in this group may be receiving support from peers who share their achievement values, in contrast to adolescents in class 2 (Negative Peer Support), whose peer support is detrimental to their motivational beliefs.

Among the three indicators, father support appears to support our developmental assets framework in positively influencing achievement motivational beliefs over time. Our findings also corroborate previous research that highlights the inconsistencies of peer relationships among African Americans (Fordham & Ogbu, 1986; Gonzales et al. 1996). Our study demonstrates three classes of African American adolescents and their peers: 1) peers promoting high achievement beliefs, 2) peers not promoting achievement beliefs, and 3) peers promoting underachievement. These findings have major implications for African American adolescents' supportive peer relationships. Interestingly, mother support did not predict academic self-efficacy beliefs in class 1, class 2, or class 3. This could be due to our analyses. More specifically, mother support was relatively high, but did not reach statistical significance. It could be the case that within this context social support systems are qualitatively different within our sample. It is not to imply that mothers are not important; however, in this context father and peer support (class 1) is beneficial. Additionally, we utilized a latent class regression model that has strengths over traditional regression methods. We identified distinct groups that could not have been identified by using traditional regression methods. Moreover, this technique grouped adolescents into classes based on their similarity in social support systems, which is a strength of this technique.

This study contributes to literatures on achievement motivational processes among African American adolescents (e.g., Butler-Barnes, Chavous, & Zimmerman, 2011; Butler-Barnes, Williams, & Chavous, 2012; Chavous et al. 2008). Our findings may aid in broader efforts to understand how social support systems influence achievement outcomes. First, our study supports prior scholarship by highlighting the important role of social support systems. Our study also underscores the use of person-oriented approaches. An additional strength of the study was examining how social support systems influenced academic self-efficacy beliefs over time.

Although the study has a number of strengths, we note limitations. First, although academic self-efficacy beliefs are an important academic outcome, future work might consider other academic outcomes (e.g., educational aspirations, high school dropout, academic persistence, and long-term academic attainment). Second, although we assessed mother, father, and peer support, future work might also consider the role of natural mentors, teacher support, and fictive kinship social support. Overall, the findings underscore the heterogeneity and intricacies of social support systems in the lives of academically at-risk African American adolescents.

Additionally, academic self-efficacy beliefs were not correlated with grade point average in our study. Yet our findings corroborated previous research on the benefits

of parent and peer support (e.g., Davis et al. 2002; Gonzalez et al. 1996) on achievement motivational beliefs. It is also important to note that despite father and peer support influence on motivational beliefs, adolescents' had low grade point averages. More specifically, adolescents' in class 1 and class 3 had grade point averages of 2.08 and 1.63, respectively. These findings suggest that our measure of parent and peer emotional support may not be appropriate in trying to understand academic performance. For instance, despite father and peer support influence on achievement motivational beliefs over time, these youth have C and D grade point averages. Future work may want to include questions that pertain to the support for academics (e.g., assistance with homework). This may be useful in identifying the type of support (e.g., emotional vs. academic support) that is most beneficial for underachievement. In addition, our lack of findings could be due to the relatively small percentage of variance that can be explained by grade point average. However, similar to most studies, social support systems do a reasonably good job predicting later academic attainment (e.g., Bean et al. 2003; Epstein, 2001; Henderson & Mapp, 2002).

CONCLUSION

Our study highlights the importance of utilizing a person-oriented framework to identify subgroups of African American adolescents who display different profiles of mother, father, and peer social support. Despite the limitations, an important finding was that father and peer support influences achievement motivation beliefs over time. Thus, programmatic and intervention efforts focused on academically at-risk adolescents might include ways to identify social support systems. At the school level, teachers, counselors, and school social workers can augment prescreen evaluations by administering strength-based assessments to identify individual-level assets and social support systems at the contextual level. Strong and supportive social support systems can alleviate stress, increase self-confidence, and decrease feelings of isolation (Cohen & Wills, 1985; Helsen, Vollebergh, & Meeus, 2000). Early identification of social support systems also allows for social support involvement in the intervention from the onset, which may be beneficial in obtaining positive outcomes. Additionally, it is also imperative to consider macro-level events (e.g., school closures), as it is during these times that adolescents may need additional resources to cope and adapt to their environmental surroundings, which underscores social support systems. In conclusion, future research should continue to explore social support systems, rather than only highlighting deficits, including how and to what extent developmental assets serve to promote academic achievement. Additionally, it is important to understand African American adolescents' personal strengths and support systems they derive from their culture and communities that allow them to achieve despite their immediate surroundings. Thus, it is critical to continue the focus on identifying additional support systems that promote academic success.

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23

Does Area Regeneration Improve Residents' Health & Well-Being?

A Novel Methodological Approach to Measuring the Health Impacts of Area Regeneration

Daryll Archibald

This chapter reports on the challenge of measuring health outcomes associated with area-based regeneration and describes the key features of a quasi-experimental approach that attempts to address these challenges in a Scottish context. It begins by exploring some of the key difficulties associated with evaluating the effects of area regeneration on health before outlining how data from the Scottish Longitudinal Study (SLS) is employed to account for neighbourhood migration issues. An overview of the regeneration initiatives analysed in this study is then provided, before a new methodological approach developed to overcome some of the challenges which have limited past evaluations is outlined.

BACKGROUND

For a developed nation, Scotland has a particularly poor health record that compares unfavourably with the rest of the United Kingdom and much of Europe. In addition, Scotland also has a large (and ever widening) gap in health inequalities, which are seen not only in terms of socio-economic groupings but also according to area of residence (Petticrew et al., 2008). Thus, premature mortality and physical and

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mental morbidity rates are all routinely found to be higher in the most deprived areas of Scotland.

One way in which successive United Kingdom governments have attempted to go about reducing health inequalities and improving health has been through the implementation of large-scale area-based initiatives. These are holistic initiatives encompassing physical, social and economic regeneration to attempt to address urban deprivation and the socio-economic-determinants of health such as employment, education, income and housing (Thomson et al., 2006). The last twenty years have seen significant government investment in area-based initiatives in Scotland and indeed the United Kingdom more generally to try to regenerate areas experiencing relative decline and close the gap on various aspects of inequality between deprived and other areas.

However, within the last decade the dearth of robust evidence demonstrating the impact of area-based regeneration on health and health inequalities has been widely lamented (Dabinett, 2001; Wanless, 2004; Rhodes et al., 2005; Kearns et al., 2009), meaning that policymakers have been unable to draw meaningful conclusions as to how area-based initiatives impact on residents' health.

This lack of evidence has been attributed to many factors. For example, Mackenbach (2003) posited that many policies and interventions targeting health inequalities have simply not been evaluated, and those that were suffered in that they were not evaluated adequately. Similarly Rhodes et al. (2005) pointed to three central deficiencies in past evaluations: (1) a limited understanding of the theory of change buttressing the policy action; (2) inadequate methods; (3) a focus on process and outputs as opposed to a focus on key outcome measures.

There are well-documented difficulties associated with attempts to rigorously evaluate area regeneration practices. For example, Petticrew et al. (2005) state that area-based regeneration is amongst a group of public health interventions (along with new roads, new housing) that are theorised to affect health inequalities but are often not amenable to randomisation for practical and political reasons. For example, practical difficulties would arise if a researcher has no control over how a government area regeneration programme is rolled-out, and it would (for example) be politically problematic and ethically dubious for a local authority to attempt to withhold a possibly beneficial intervention from a control group.

Consequently, the practical and ethical difficulties associated with evaluating public health interventions with randomised trials render them unsuitable in the majority of cases. Petticrew et al. (2005) thus argue that researchers can partially "fill the gaps" in knowledge by exploiting opportunities offered by natural experiments. Similarly Des Jarlais et al. (2004) conclude that non-randomised evaluation designs such as quasi-experimental designs, non-randomised trials and natural experiments should be employed, as they can "provide a more integrated picture of the existing evidence and could help to strengthen public health practice".

KEY CHALLENGES TO EFFECTIVE NON-RANDOMISED EVALUATIONS

The Counterfactual

Key difficulties are presented to the researcher attempting to measure outcomes associated with area regeneration using non-experimental research designs. In particular, attempts to provide an estimation of the counterfactual (i.e., what would have happened in the absence of the initiative) to establish average treatment effects is challenging. It is essential that treatment and control groups have comparable characteristics related to treatment assignment and the outcome variable of interest. Thus, Aussems et al. (2009) explain that thoughtful design and analysis of quasi-experimental data are crucial, because it is *the* way to reduce the impact of selection bias in estimating a treatment effect. Selection bias refers to any factor other than the programme that leads to post-test differences between groups. Unbalanced treatment and control groups are therefore regarded as being perhaps the greatest limitation associated with quasi-experimental designs. Thus, we attempt to provide an estimation of the counterfactual by using the propensity score-matching technique which aims to balance two non-equivalent groups based on observed covariates to gain a more precise estimate of the effects of a treatment on which the two groups differ (Luellen, 2005). A more detailed account of the matching process will appear later in this paper. However, further issues such as time lag and migration should also be considered here. The following briefly describes these issues.

Time Lag

It is common for evaluations to use relatively short time lags (< 5 years) post-initiation of regeneration programmes to attempt to observe changes in specified health outcomes. However, Cotterill et al. (2008) suggest it is likely that time lags of less than five years are insufficient for changes in trends of disease morbidity or mortality to occur:

> Even if such (area-based) interventions are effective in modifying disease aetiology and progression, the problem of time-lag remains and long-term follow-up (>10–20 years) is required if change is to be noted. Unfortunately, policy-makers want to know 'what works' now and extended community follow-up over decades is rarely feasible within existing resource envelopes.

However, the idea that extended follow up over long periods is unfeasible is also partly due to the rates of migration that some communities experience.

Migration

Some past evaluations (Huxley et al., 2004; Stafford et al., 2008) have at points suffered in that their design does not permit the tracking of individuals through

time, resolving instead to compare population characteristics before and after the regeneration process, thus not accounting for the fact that the resident population may have changed substantially during this period. Therefore, studies have used shorter time lags, as when rates of mobility in study areas increase, the likelihood of further moves and loss of contact with respondents results, to the extent that by five years or more the study numbers may have been either too small to conduct meaningful quantitative analysis or the analysis cannot claim to know how those originally targeted by the initiative have fared.

Bailey & Livingston (2008) state that selective migration flows are a key means by which the intended benefits of area-based initiatives 'leak out' of target areas, and so undermining their effectiveness. Cole et al. (2007) refer to this problem as the 'moving escalator', which can arise from existing tensions between the central objectives of area regeneration initiatives. For example, whilst holistic regeneration strategies may improve the physical environment in order to make fewer residents want to leave, they simultaneously, on the other hand, may improve life chances through education and health promotion, which see residents want to (and actually be able to) move away, leading to them being replaced by relatively disadvantaged in-movers, which ultimately results in steadily more deprived communities (Cole et al., 2007), that is, those who 'get on' 'get out'. What is therefore required is longitudinal data that follows changes in outcomes and personal, household, and ecological characteristics of a programme's intended beneficiaries (Gutierrez-Romero & Noble, 2008).

USING SLS DATA TO OVERCOME THESE CHALLENGES

With this in mind, this study uses data from the Scottish Longitudinal Study's (SLS), a 5.3 percent sample (around 270,000 individuals) of the Scottish population. The dataset includes a range of routinely collected information including 1991 and 2001 census data, vital events (births, deaths, marriages, etc.) data, cancer registry and hospital admissions data. A key advantage of using the SLS is that it enables one to follow individuals through time and thus account for migratory patterns in regeneration areas. The SLS data also therefore permits a longer time period (1991 to 2001) to observe the effects of area regeneration initiatives than some other evaluations have had. However, given that the data is predominantly based around records from United Kingdom K census data (beginning in 1991), an extended follow-up (>10 years) will not be possible until the records from the upcoming 2011 UK census are integrated into the SLS. Nevertheless, in using the SLS one can access records for a period of ten years. In addition, the large sample of 270,000 individuals included in the SLS overcomes the problem of small sample sizes that have limited the ability of other studies to generalize their findings to the wider population.

Consequently, data from the SLS is employed to compare health outcomes for three groups of people: (a) those who have lived in regeneration areas in 1991 and 2001; (b) those who lived in such areas in 1991 but had left by 2001; (c) those who

were living somewhere else in 1991 but had moved into a regeneration area by 2001. Outcomes for three similar groups living in significantly deprived areas in Scotland that did not experience regeneration between 1991 and 2001 are compared in order to identify effects that cannot be ascribed to regeneration and thus to draw some broad conclusions about the effects of the regeneration process in Scotland.

COMPREHENSIVE AREA REGENERATION IN SCOTLAND 1991–2001

Three major area-based initiatives were introduced to Scotland in the 1990s (Fyfe (2009):

- Priority Partnership Areas (PPA) (1996–1999)
- Regeneration Programme Areas (RPA) (1996–1999)
- Social Inclusion Partnerships (SIP) (1999–2006)

In 1996, local authorities, backed by other local partners, were asked to apply to the (pre-devolution) Scottish Office for support for urban regeneration strategies in areas to be designated as Priority Partnership Areas (PPA). The PPA programme was designed to bring together local and central government along with the private sector and other organisations (most notably local health boards) in a comprehensive urban regeneration strategy focused on geographical neighbourhoods, the majority of which were amongst Scotland's 10 percent most disadvantaged and contained populations of five thousand to thirty thousand people. The programme also promoted community participation in projects involved in the wider regeneration strategy. The PPA strategy centered on improving conditions in areas experiencing the most significant disadvantage measured on key socio-economic and health indicators. However, seventeen of the twenty-nine bids for PPA funding were unsuccessful following the bidding process, which has since been heavily criticised on various fronts (Taylor et al., 1999). This left twelve areas which were successful in attaining PPA designation.

Shortly thereafter however, nine of the seventeen areas that were unsuccessful in their bids for PPA funding were awarded compensatory 'Regeneration Programme' (RP) funding by the Scottish Office. RP area programmes differed from PPAs only in that their funding was originally designed to last for five years as opposed to ten years for the PPA initiative (SIP Monitoring & Evaluation Unit 1998). Thus, from 1996 a comprehensive physical, social and economic area regeneration strategy commenced in twenty-one of Scotland's most disadvantaged areas, twelve of which operated under the PPA banner (10 years funding) and nine under the RP designation (five years funding).

Table 23.1 lists the areas attached to each programme.

However, Scotland's area regeneration strategy was somewhat altered following the UK general election of 1997. The incoming New Labour administration quickly

Table 23.1. List of PPA and RP Areas

Designated PPAs in Scotland (1996) n=12	*Designated RPs in Scotland (1996) n=9*
Aberdeen	Cambuslang (South Lanarkshire)
Craigmillar	Dundee (various areas)
Dundee (various areas)	East Renfrewshire (Levern Valley)
Easterhouse	Edinburgh (Leith Prestonfield)
Edinburgh North	Falkirk
Glasgow East	Fife (various areas)
Glasgow North	North Ayrshire
Inverclyde	North Lanarkshire
Motherwell	Stirling
Renfrewshire	
South Ayrshire	
West Dunbartonshire	

announced that the twenty-one PPA and RP areas would evolve into a new regeneration initiative named 'Social Inclusion Partnerships (SIP) *without any revision of boundaries* (Taylor, 2002). Nevertheless, despite the rebranding, the broad holistic focus on social, environmental and economic issues was retained. The transition commenced formally in April 1999 with the new SIP areas given designated funding until 2006. The SIPs initiative had broadly the same aims as the PPA and RP programmes, in applying a comprehensive partner-led approach focusing on social, economic and physical renewal of disadvantaged areas. However, the key shift was towards a focus on tackling social exclusion. The thinking behind the SIP programme identified social exclusion as a primary factor in causing urban decline and thus attempted to address this through providing means to 'include' groups thought to be socially excluded such as young people, ethnic minorities, and others. The SIP programme therefore had the goal of addressing what were thought to be the underlying causes of urban decline, which was spun politically as a break from previous regeneration policies that only planned to ameliorate the effects of decline. The key characteristics of SIPs were:

- to focus on the most needy members of society
- to co-ordinate and fill gaps between existing programmes to promote social inclusion
- seek to prevent social exclusion happening in the first place (Taylor 2002)

In addition, twenty-seven new SIP areas were announced which were not included in this analysis; thirteen of the new SIP initiatives were area based and fourteen were thematic. Thematic SIP programmes concentrated on excluded groups within and out with the most deprived neighbourhoods and focused on, for example, young people or ethnic minorities. The initial total funding for SIPs in 1999 to 2000 was £46 million rising to £60 million in 2003 to 2004.

The SIP programme was evaluated by performance on sixteen core indicators covering population, housing, crime, employment and training, education, health and community engagement. However, a recent overview of the SIP programme found that poor baseline data had been collected for the programme and limited resources were given over for monitoring and performance measurement, meaning that the core indicators were not monitored adequately (ODS Consulting, 2006). This is echoed by Petticrew et al. (2008) who (in regards to health outcomes) state that "the extent to which the SIPs scheme was successful in promoting good health is unclear as impacts on health outcomes were often not measured".

Lack of baseline data and poor data collection more generally is widely acknowledged to have beset UK government area-based initiatives. Indeed, in 2009 the House of Commons Health Committee (appointed to examine the policy, administration and expenditure of the Department of Health) inquiry on health inequalities found that

> the most damning criticisms of Government policies we have heard in this inquiry have not been of the policies themselves, but rather of the Government's approach to designing and introducing new policies which make meaningful evaluation impossible. As one witness described, "there is a continual procession of area-based initiatives and that in itself is quite disruptive. Nothing is given time to really bed in and function.

This evidence would seem to concisely encapsulate the experience of area regeneration in Scotland through the 1990s outlined above. However, given that the SIP programme operated within the original boundaries of the PPA and RP programmes and focused on broadly the same issues, this study focuses on the twenty-one SIP areas that originally had PPA and RP designation from 1996. This work therefore adds to the literature on the health effects of area regeneration practices by utilising data from the Scottish Longitudinal Study (SLS) to shed light on how residents in the twenty-one SIP areas fared on selected health outcomes over time, which is important as evaluations of these initiatives is scarce at present.

ESTABLISHING THE REGENERATION AREA BOUNDARIES

Measuring the health effects of area regeneration programmes over time presents a series of challenges to overcome. One central challenge is that, between 1991 and 2001, census boundaries changed in Scotland, making it difficult to compare health trends for small areas. To combat this we employed Exeter et al.'s (2005) Consistent Areas Through Time (CATTs). CATTs are aggregate of the 1981, 1991 and 2001 UK census output areas (COAs). The construction of CATTs was conducted to ensure they are consistent through the 1981, 1991, and 2001 UK censuses and therefore allows for reliable analysis of varying demographic, social and economic circumstances at the local level.

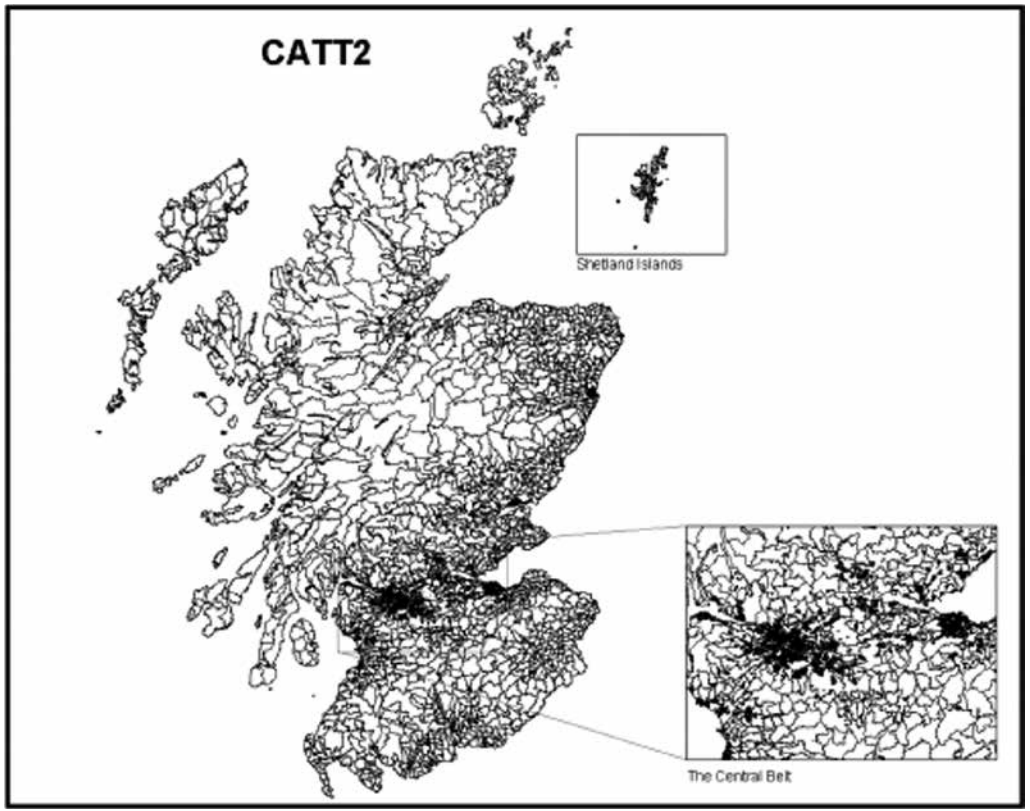

Figure 23.1. Map Showing the 10,058 CATTs in Scotland.

Source: Exeter (2004).

Given that a means for comparing small areas between 1991 and 2001 was acquired, the next step was to establish the boundaries of the regeneration areas we were interested in. We wanted to analyse the twenty-one areas that had PPA and RP regeneration status in 1996, which subsequently evolved into SIP areas in 1999. This would allow for a five-year time lag (1996–2001) in which to observe any changes in health trends, using 1991 as a baseline. To establish these regeneration boundaries we requested PPA and RP boundary data from the Scottish government, which was delivered in the form of postcodes. Once in possession of this data we used ArcGIS to link the boundary data to Census Output Areas (COAs), which are the smallest unit of census geography in the UK. Once the boundaries of these regeneration areas were established at COA level we then linked these into the CATTs system so that we had a list of CATTs defined as PPA and RP areas in 1996, effectively giving us a treatment group. Thus, the CATTs system enabled us to be in a position whereby we could observe how these areas had changed from 1991 to 2001.

Of the 10,058 CATT areas in Scotland the linkage of PPA/RP areas to CATTs identified 1,384 CATTs that could be defined as regeneration areas. However, twenty-one were removed because they were too large and encroaching into rural areas. In addition, eighteen were dropped because they were found to be in the least deprived of deprivation quintiles. This left 1,345 regenerated CATTs, which subsequently meant that 8,674 CATTs remained to potentially be employed as control areas.

ESTABLISHING CONTROL AREAS: PROPENSITY MATCHING

Here we use a quasi-experimental design to establish the counterfactual. Despite being unable to definitively establish a link between cause and effect, quasi-experiments can inform discussion of causal pathways. For example, they can provide information on who is being served by a programme, and can reveal whether a programme is reaching its original intended recipients. Also, expected outputs and outcomes can be identified by quasi-experimentation, and if these are tracked over time, we can confirm or disconfirm that expected changes are occurring (Anderson-Moore 2008). Also, these designs can result in study conditions that can be more like real-world settings than randomised experiments as, for example, experiments use less representative participants such as volunteers or less representative settings willing to accept random assignment.

Leyland (2010) states that "if the community is the unit of intervention then it is at the community and not the individual level that balance must be achieved." With this in mind, to provide a measure of the counterfactual, the next stage of the analysis involved selecting appropriate control CATT areas. We matched on areas as opposed to individuals within areas due to the nature of the 'treatments' we were interested in; that is, regeneration initiatives that specifically targeted *areas.* This was carried out using the propensity score matching technique. The propensity score is defined

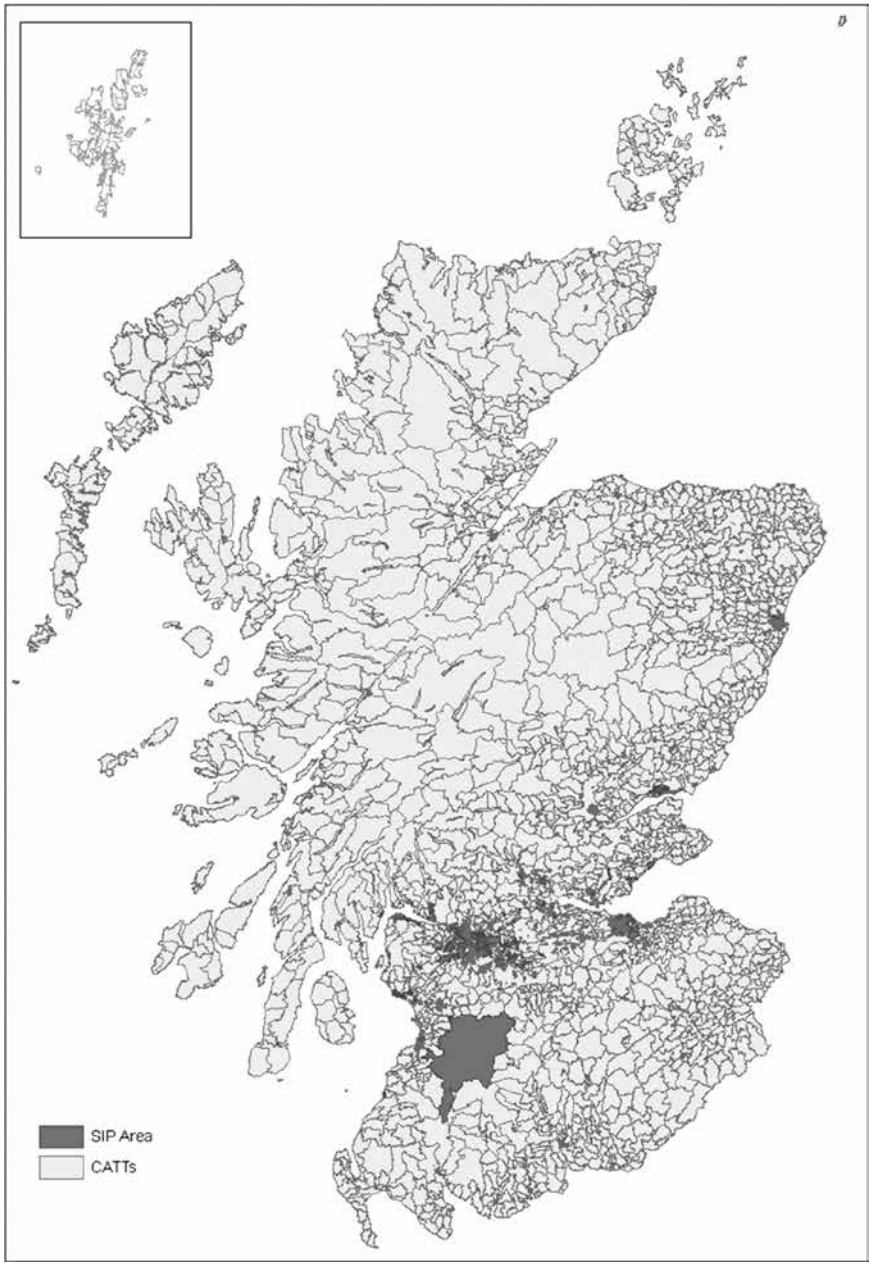

Figure 23.2. Map Showing SIP Regeneration Area Boundaries in Scotland.

as the conditional probability of receiving treatment given the set of confounders (Rosenbaum & Rubin 1983). Propensity scores reduce the discrepancies observed in the characteristics of treatment and control groups, and to this end reduce the bias in estimation of the treatment effects with observational data like surveys, administrative records and census data. However, matching on propensity scores can suffer if poorly measured variables are employed to obtain the propensity score (Bryson et al., 2003). In this case, deprivation variables from the 1991 UK census were used to ensure the variables were of good quality.

To this end, we extracted thirty-four deprivation variables from the 1991 census and used PSMATCH2 in STATA 10 for the propensity-matching procedure (Leuven and Sianesi, 2003) in order to identify places that match the socio-economic and demographic characteristics of our regeneration area as closely as possible so that we effectively had a control and treatment group. What we did involved the following steps:

i. First we extracted 34, 1991 census deprivation variables from Casweb, a resource based at the University of Manchester that allows the downloading of aggregate UK census statistics and digital boundary data developed by the Census Dissemination (http://casweb.mimas.ac.uk/). Amongst these variables were the four variables that make up the Carstairs deprivation index. The Carstairs Index deprivation score is a widely recognised geographical measure of material deprivation that was specially created for the Scottish context (Carstairs & Morris, 1989; Morris & Carstairs, 1991). The Index is a composite score based on (1) the percentage of unemployed male residents over sixteen; (2) the percentage of persons in households with one or more persons per room; (3) the percentage of residents in households with no car; and (4) the percentage of residents in households with an economically active head of household in social class IV or V (Boyle et al., 2002).
ii. These thirty-four variables were aggregated into the CATTs system.
iii. We then proceeded to create the control areas using PSMATCH2 in STATA 10.1. We created three types of control areas with differing geographical characteristics with the aim of comparing how these characteristics will affect the findings. All three sets were created using the 'nearest neighbour' matching technique. Care was taken to ensure that the control areas were not included in the PPA RP or SIP programmes, and to the best of our knowledge, they were not included in any other area-based initiatives in the past. The nearest neighbour matching technique randomly sorts the treatment and control CATTs before the first treatment CATT is chosen to find its closest control match based on the total value of the difference of the propensity score (or the logit of the propensity score) of the selected treatment and the control under consideration (Coca Peraillon, 2006). The closest control CATT is then selected as a match. This process (which is then repeated for all the treatment CATTs) makes sure that each treated CATT finds a match even if the propensity scores are not close, provided there are enough controls available.

Table 23.2. Characteristics of the Control Groups

Control Group	*Matching Type*	*Conditions*
1st Set	One to One Nearest Neighbour	With grid references (X, Y) as co-variates. This favours areas close to regeneration areas (i.e., in the same local authority)
2nd Set	One to One Nearest Neighbour	Without grid references (X, Y) co-variates, geographical location is not taken into account, thus control areas can be drawn from matched areas anywhere in Scotland.
3rd Set	One to One Nearest Neighbour	With grid references (X,Y), in the same local authority and excluding CATTS contiguous to regeneration CATTs

In conducting the nearest neighbour matching, we also imposed a caliper. Treatment and control CATTs are only matched if the control's propensity score is within a certain radius. The radius is thus controlled by the imposed caliper. Consequently, use of the caliper method means that a treated CATT may not be matched to a control as the aim is to avoid bad matching. Table 23.2 shows the central features of the three control CATTs.

These three sets of control areas were then checked to ensure that they were well balanced with the treatment areas on all variables (i.e., no significant difference on any of the 1991 census variables between treated and control areas). When this was successfully completed, the control areas were attached to the individual-level data from the Scottish Longitudinal Study (SLS) in preparation for the analysis stage.

When interpreting the prospective results of the analyses using the three sets of control areas, it is of importance to be mindful of how their respective characteristics may affect the findings. For example, Cotterill et al. (2008) argue that in a quasi-experimental analysis (such as this), control areas should be as similar as possible to the treatment areas, and thus must be located in the same local authority as the regeneration area, with the exception that they have not been targeted by the intervention. With this in mind, one can observe from table 23.2 that the second set of control areas does not accord with this assertion, as these areas are drawn from matched CATTs anywhere in Scotland. This therefore represents a potential weakness of employing the second set of control areas that must be taken into account when interpreting the findings. In contrast, the first and third set of control areas therefore appear to have particular advantages in that they are created to include similarly deprived areas within the same local authority as the regeneration areas. However, the third set of controls also possesses a further advantage in that these areas are also not geographically contiguous to regeneration areas. Selecting areas that are not contiguous to regeneration areas was undertaken to account for potential spillover effects of the regeneration programme into control areas. Gutierrez-Romero (2009) notes that the implementation of policies such as area regeneration at the small-area level can impact on households not directly participating in the programme due to spillover

effects. Thus, spillover effects are likely to occur when the involvement of residents in regeneration activities enhances social networks, creating links between both participants in regeneration activities and non-participants (Gutierrez-Romero 2009).

It would appear therefore that the analyses which employ the third set of control areas may well yield the most meaningful results of the three sets created in that they are located (roughly) within the same local authority as the regeneration areas (enhancing their probability of possessing similar characteristics to the regeneration areas), and are also non-contiguous to regeneration areas which controls for any potential spillover effects from regeneration areas into control areas. With this in mind, the analysis stage will proceed by exploring how the differing geographical characteristics of each set of control areas affect the research findings.

CONCLUSION

In conclusion, this paper has sought to address a number of issues. Firstly, some of the key challenges faced by researchers attempting to measure outcomes associated with area-based regeneration have been presented, and secondly the paper demonstrated how data from the Scottish Longitudinal Study (SLS) can track individuals over time and extend time lags for observing changes in health outcomes. Thirdly, the paper has presented an overview of the regeneration initiatives analysed in the study and shown evidence to demonstrate the need that currently exists to evaluate the impact that these initiatives have had on residents' health. Fourthly, the paper has also shown how Exeter et al.'s (2005) time-consistent geography methodology which allows one to reliably compare small areas over time has been employed. Lastly, the paper has shown how propensity score matching has been employed to establish control areas that will allow an indication of the counterfactual and how applying each of the control areas may affect the prospective findings.

Finally, area-based regeneration is seen in as a strategy for tackling the poor health and health inequalities that many of the most disadvantaged members of society in Scotland experience simply by virtue of their socio-economic status and area of residence. However, it is currently unclear if these initiatives are succeeding. This is encapsulated by Thomson (2008):

> From the scant amount of impact data available there is much uncertainty around whether area-based-initiatives do impact positively on health or the socioeconomic determinants of health; with even less known about the social distribution of impacts and the implications for health inequalities. (However) it is important to remember that this uncertainty should be interpreted as absence of evidence rather than evidence of absence.

Thus, unlike many past evaluations, this longitudinal study will contribute to understanding how area regeneration has influenced the health of those who actually experienced it by following individuals through time. The study will therefore help to improve the rigour of the currently limited evidence base, which in turn may assist in

the development of more effective policy aimed at tackling socio-economic deprivation through area-based initiatives.

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24

The Twenty-First-Century Gold Coast and Slum

Robert J. Sampson

The Chicago communities featured in Harvey Zorbaugh's *The Gold Coast and the Slum* (1929), published over eighty years ago, have been transformed by history and profound demographic change. But for Zorbaugh the interesting puzzle was social differentiation and not the manifest characteristic or group of the moment. Italians were linked to violence and urban mayhem in the Near North Side's Little Sicily (often referred to as "Little Hell") in the Roaring Twenties. But in the wake of further European immigration, the great migration from the rural South, neighborhood racial change, and Chicago's decision to build segregated large-scale public housing, the "slum" half of Zorbaugh's contrast was transformed demographically. Cabrini-Green in the late twentieth century became a national symbol of the high-rise containment of the urban poor, housing over four thousand predominantly black families just blocks away from the white wealthy areas of the Gold Coast. As recently as 2003, CBS's national *60 Minutes* program called Cabrini "the nation's most infamous public housing project, synonymous with gangs, drugs, misery and murder" (Kohn, 2003).

How does social difference and social distance play out today, if at all? Amid great fanfare, most of the Cabrini-Green project has since been "removed" under the city of Chicago's "Plan for Transformation." Thousands of families were displaced to other units (exactly where, no one is really sure) and the buildings demolished, like the Robert Taylor Homes on the South Side. In a fundamental sense, the Zorbaugh contrast has been radically and purposely reshaped by governmental intervention. Given Cabrini's proximity to wealth and the Near North Side's "Magnificent Mile," many had predicted considerable economic investment

*This chapter is an edited version of chapter 17 originally published in Sampson (2012).

and in-migration of the well-to-do—in essence, that a new neighborhood would emerge in short order. The 2003 CBS report, for example, conjured up an unambiguous image of "beautiful new mixed-income developments—rich and poor living side by side." Several years later, one can argue that in some ways this is true; a case for "positive" change can be made. In the northern part of the neighborhood, market-rate units in the mixed-income North Town Village sold briskly in the mid-2000s. Closer to Cabrini's many housing units, in March of 2007 a woman begged for money near a large sign outside new condos and a gym on North Larrabee Street with the bold proclamation: "Look Better Naked" (Sampson, 2012: 13). Today that sign is gone, as is the woman begging, and the people going in and out of the building to exercise, look like any other health-conscious young professionals in a major American city.

But seen from another lens, those streaming in and out of the gym are the opposite of a racially integrated scene, and two blocks away I observed what appeared to be a homeless woman walking slowly across an empty lot with a torn suitcase, heading toward an abandoned building. Physical decay is still present in many blocks, with a large number of boarded-up buildings near West Oak and North Hudson. Moreover, a remaining unit of Cabrini still showed signs of inhabitation, with people huddled behind wire meshing installed to secure the otherwise open gangways. Even on a sunny day I could not see faces clearly, but I heard a number of women's voices. Middle-aged men hung around outside, apparently unemployed. As I walked around the side of the building, a dead rat that had been bludgeoned lay on its back near an open garbage bin that reeked of uncollected refuse. Two blocks to the east was Munchies Grocery, a convenience store with a hard-bitten look. None of the young professionals I encountered in the far western area of the neighborhood ventured near it on my visit, nor to the nearly abandoned project that was allegedly to be torn down any day. Sadly, on the last day of my final visit to this neighborhood, on October 16, 2010, the owner of Munchies was shot in the back and murdered by an unknown assailant.

DEATH CORNER

Is the glass of community change half empty or half full? According to Zorbaugh (1929, 171), the intersection of Oak and Cambridge in Chicago's Little Hell of the 1920s was "known throughout the city as Death Corner." A short stride from Munchies Grocery, this intersection sits today in the heart of what used to be the Cabrini-Green neighborhood. I thus figured this was a socially and historically strategic site to re-observe up-close Zorbaugh's twenty-first-century manifestation. On June 10, 2010, and a stone's throw from Cabrini's rubble, I observed men sitting around a makeshift table on the sidewalk on the east side of North Cambridge about ten yards south of Oak. They appeared to be playing cards, with about four to five other men leaning against nearby cars and an empty lot stretched out across the

street. In the distance, new multiunit housing could be seen to the west, and to the east one could see the skyline of the southern Gold Coast.

On the corner stood an abandoned building with a chain across its entrance door, broken windows, and a "price reduced" sign. The men were just around the corner to the right of the building. Across from the building was an empty lot, and litter easily noticed. These multiple signs of "disorder" are not uncommon in certain Chicago neighborhoods, but a BMW was parked in front (behind a car with no hubcaps), and upscale new housing (low-rise units) were visible to the west. Perhaps the BMW belonged to a local professional who lived in one of the half-million-dollar condos just three blocks away (on North Crosby, extending both north and south of Oak), or perhaps, more cynically, it belonged to a suburban buyer of drugs visiting for a short transaction. I cannot say, and as my findings elsewhere show, that context pervades our perceptions about what is, and is not, disorder. The implication is that I am no more unbiased than the reader.

Hence a considerable degree of uncertainty pervaded the public spaces around this particular corner on this day. Was I seeing gentrification in progress? Transformation momentarily stalled? Or is this area too tainted by the past, with the stain of murders in the streets and corner stores too much to overcome? It is rather remarkable, after all, that this is the same area Zorbaugh highlighted in the 1920s Italian slum of his day, cheek by jowl with the Gold Coast. One senses that some things are really not that different when it comes to the concepts of social distance, spatial proximity, violence, and perceptions of difference, both in the physical and social environments.

Bothered by these questions, I made a final trip to Death Corner and the Near North Side in October of 2010 to recheck key observations. The Near North along the Magnificent Mile and Gold Coast looked as opulent as ever. Tourists jammed the streets on a nice fall day but thinned out dramatically once I headed west and crossed the vicinity of North State. Along West Oak Street east of North Cambridge, I found the same vacant units as in the summer. The abandoned building on "Death Corner" remained boarded up and chained, and upon closer inspection, I noted a "water service termination" notice on the door. A group of men were hanging out in the late afternoon near the building, but now about eight to ten in number and gathered on the west side of the street about twenty yards from my last visit. Soon after passing the group of men, one asked me directly, "Did you find any?" Walking south on Larrabee, a block to the west, there were empty storefronts near upscale buildings as I approached North Kingsbury and then West Chicago Avenue. A community garden was active along the south side of Cambridge, near Chicago Avenue. The contrasts were a bit surreal, with a gardenlike atmosphere so close to abandonment.

As I walked north from the garden, I passed a long stretch of low-rise, mostly boarded-up projects. Black plywood covered the majority of doors, especially on the east side of the street. Despite the abandoned feel, I encountered a surprising number of people on the street, all African American. A number of children were playing, and mothers stood in doorways while men and teenagers milled about in the street. I was the only white person for several more blocks—this slice of the Near North

Side was completely segregated racially. As I circled back to the abandoned building on Zorbaugh's Death Corner, I felt wary when I came across two men sprawled out near the back side of the empty building, one flat on his back and passed out. The other was drooping and bobbing, as if about to fall over, with glassy eyes. But then one man crossing the street greeted me jovially with a "Hey, man" and a wide grin. I returned the greeting and moved on.

The next morning at 11 a.m. the group was in the same spot, only this time a number of apparently homeless men had joined them. Blankets were strewn about, and a grocery cart that was not there the day before was visible. Geese grazed in an empty field across the street while construction hummed in the background on the site of the former high-rises. The field was cleaned up from the summer and a surreal feeling pervaded, as it did in Grand Boulevard, when I was similarly strolling in an empty space that once housed thousands of residents of the Robert Taylor Homes. Uncertainty about the future of these remaining inhabitants weighed on my mind as I exited for the last time. Walking through an alley, not two blocks from Oak and Cambridge, I came across an arresting stretch of graffiti on the back of a building. The realities of concentrated incarceration, racial inequality, and a life of constrained options was brought to life by the author, perhaps a child, in poignant form. In two sketches were the grim faces of black men behind prison bars. Under one was drawn an open book with the message, "You must have power to fight power." The second message continued, "Intelligence is not fighting the powers that be but developing the powers to be," with a diploma drawn beneath. The images were jarring, but I was struck by the sense of resistance to racial subjugation and the sense of a pathway forward through education.

LESSONS OF TIME AND CONTEXT

The corner of Oak and Cambridge in the twenty-first century is a work in progress, as it was in Zorbaugh's day. Change has come, to be sure, but in nuanced ways social mechanisms differentiating the Gold Coast and the slum are still churning at some fundamental level. Whether concentrated inequality, race/ethnic segregation, perceptions of (dis)order, shared expectations for social control of public places, cynicism about the future, incarceration's penetration in the black community, spatial proximity to (dis)advantage, imbalanced inflows and outflows of residents (selection), network ties among key leaders over neighborhood economic development, foreclosures, or organizational resistance by residents, multiple layers of individual, neighborhood, and structural effects are simultaneously being negotiated and reproduced. I have also argued that it is difficult to overcome cultural reputations and legacies of severe disadvantage (Sampson 2012), making it a mistake in the first place to predict a community's trajectory solely on the basis of economic forces. It is not surprising that the predictions of city officials and pundits alike have not materialized.

Once the economy recovers and the dislocation induced by the takedown of Cabrini fades, however, the social and spatial logic of neighborhood effects suggests that the transition will ultimately be complete. Cabrini's legacy of disadvantage, deep as it was, has a lower reputational and spatial handicap to overcome than its counterparts on the South Side. To be clear, I am not suggesting that transformation is necessarily a good thing, or that change is inevitably in the direction of progress. Seeming to defy "rational" logic, for example, while some cheered the neighborhood's demolition, other Cabrini residents banded together to protest being forcibly removed from the projects—it was, after all, a place they called home. And the self-interests of developers are hardly virtuous. A website designed to promote neighborhood real estate is perhaps too transparent in its wishes that the Gold Coast will quickly finish the annexation of Cabrini's ashes: "Already infused with chic dining spots, grocery stores and a growing shopping district, Cabrini-Green is the Chicago neighborhood of the future." I thus have no illusions, then, that the rich "living side by side" with the poor will occur in other than a minority of housing units. The side by side will likely be separated by a perceived and actual physical distance, especially for the many men to be released from prison in the coming years. Reintegration into the community will take place in a profoundly altered landscape.

My larger point is analytic—Death Corner and its subsequent manifestations over many years embody in a microcosm the neighborhood mechanisms and interlocking structure of Chicago that I emphasized in *Great American City* (Sampson, 2012). One cannot be understood apart from the other, as the fates of both are intertwined. In other words, contextual causality is at work. The twenty-first-century Gold Coast and slum also encapsulate a set of lessons in thinking about how to intervene more constructively to meet social challenges and reduce urban inequality.

INTERVENING AT THE SCALE OF COMMUNITY AND CITY

Consistent with the individualist American ideal, the dominant policy approach to reducing inequality by place starts with the premise of promoting individual choice. This dominance is highlighted symbolically and concretely in the voucher movement, one that advocates vouchers as a way to move individuals away from whatever bad school or bad community that inequality has wrought. But more than just move individuals away, an allied policy is to eradicate the damaged community left behind. The stories of Cabrini-Green and the Robert Taylor Homes are emblematic of this logic, where "escape from the ghetto" is followed by its demolition. In a kind of morality play, the disadvantaged communities of origin are first demonized, giving rise to support for their removal, followed by the promotion of vouchers for the individuals displaced. The teardown approach to urban poverty policy is eerily familiar, despite claims that we have learned from the past. Indeed, the urban renewal of the 1950s and 1960s operated on similar assumptions about the need to raze entire

neighborhoods of the disreputable urban poor. *The Urban Villagers* is perhaps the most famous sociological account of the unintended consequences of urban renewal in the mid-twentieth century (Gans, 1962). In this case an Italian slum was eradicated in the West End of Boston, suggesting a general mechanism at work.

A different approach to policy is to intervene holistically at the scale of neighborhoods, communities, and cities themselves. Rather than simply move people out of targeted communities, the idea is to renew what is already there while simultaneously investing in communities on the edge of critical need but not yet deemed policy-relevant. In Chicago and its environs today, this second group of communities constitutes the predictable destinations of public-housing refugees. To be clear, I have no wish to argue against increasing individual opportunities, and I have confronted full bore the undeniable social problems that places like Cabrini-Green and the Robert Taylor Homes endured. Rather than argue negatively, or against vouchers, I wish to make a positive case by emphasizing a point brought to life in this book: communities can serve as a unit not just of social science theory and method, but of holistic policy intervention that prioritizes the interconnected social fabric. When urban infrastructure in cities is discussed in macro-level or community terms, concerns usually turn first to physical or material manifestations (e.g., roads, economic development, housing designs). Physical infrastructure and housing are crucial, but so too is the social infrastructure.

In short, I want to make the dual case for community-level intervention instead of individual-level escape hatches and a government policy focus on the interlocking social infrastructure in the neighborhoods of American cities. My intent is not to evaluate or proffer specific interventions but to point the way toward how a new agenda might be conceived. From this view, ideas rather than specific policies should be the guide, and the goal of research should be to provide robust knowledge. Their translation into practice requires the skills and equal partnership of those on the front lines and in positions of power to make things happen.

Based on the theory and research in Sampson (2012), I believe that we need to first pay special attention to integrating violence interventions with other efforts to rebuild communities at risk. Although "things go together," safety is a fundamental condition for humans to flourish, and, as a result, violence is a leading indicator of a community's viability over the long run. As the children in Cabrini-Green experienced and our research verified, even the basics of cognitive learning ability are harmed in the midst of violence (see also Sharkey, 2010). There is no magic bullet of violence prevention, but there are promising efforts with a community focus that deserve further scrutiny. One is Operation Ceasefire, now in operation in multiple cities, including Chicago. As we saw in action in Roseland, the goal is to reduce the risk of future violence while at the same time promoting adult-teen relationships and attempting to sustain the community's collective efficacy. In a similar vein, there is evidence that "community policing" can work when it genuinely integrates crime policy with efforts to build networks of informal social control, trust, and

collective efficacy. One mechanism is the regular meetings of police and residents on neutral turf (e.g., in a school or church) where both sides identify the location of problems (e.g., "hotspots") and targeted place-based solutions are then pursued (Skogan & Hartnett, 1997). Informal social control and citizen input is thus brought into alignment, at least in theory, with official forms of problem solving and crime reduction.

Community re-entry programs for ex-prisoners should be added to the safety agenda, given the severe neighborhood concentration of incarceration and the known vulnerabilities of ex-prisoners, especially in the job market (Western, 2006). I have shown how the nation's experiment with "mass" incarceration is in fact highly stratified locally, transforming some Chicago communities into hyper-incarcerated outliers with prison intake rates almost inconceivably high (Sampson, 2012, 114). Exiting one dysfunctional social system into such stigmatized and resource disadvantaged communities is virtually a recipe for recidivism. But perhaps a concern with community pre-entry should take precedence. Reducing the number of new admissions to prison is a goal that research shows can be achieved at the same time as reducing crime (Durlauf & Nagin, 2011). The key to success is smarter and more efficient policing, yoked to a community-based focus that stresses good police-citizen relationships. The perceived legitimacy of criminal justice institutions is likely to be reinforced with such a policy move, whether among adult ex-prisoners or the children growing up in the neighborhood whose future encounters with the law are at stake. Recall that legal cynicism was a central concept that emerged in my analysis—where mistrust of the law and cynicism about institutions are prevalent, community norms erode and violence is expected as a routine feature of everyday life. Thus the nexus of incarceration, policing, and institutional legitimacy is ignored at our peril, but, at the same time, the research here suggests constructive options for a holistic counter-response.

I believe it is therefore essential that we take a broader view and integrate public safety interventions with more general noncrime policies that address antecedent and mediating processes of social and cultural organization. Whether through the enhancement of age-graded mentorship and monitoring of adolescent activities as a form of collective efficacy, increasing organizational opportunities for citizen participation in decision making, or enhancing the legitimacy of government institutions that have eroded trust among those served, we need a surgical-like attention to repairing or renewing existing structures rather than simply designing escape routes. Sometimes triage is necessary in an emergency, of course, but in my experience Chicago is not on the stretcher—even the worst-off communities command human assets and organizational potential that have not been fully harnessed. In fact, my data support the notion that disadvantaged communities sometimes have rather high levels of other-regarding behavior and latent collective efficacy that are otherwise suppressed by the cumulative disadvantages built up after repeated everyday challenges (Sampson, 2012).

The logic of my inquiry clearly moves us beyond the borders of any single neighborhood, however, and to a concern with organizational, political, and macro-social forces. Citywide or metropolitan policies on mixed-income housing and community economic development are theoretically relevant because they are inextricably tied to neighborhood-level dynamics of migration and leadership connections (Sampson, 2012). The destruction of the Robert Taylor Homes and Cabrini-Green came with offsetting promises of mixed-income renewal, and there is evidence in this direction to the credit of Chicago's leadership. But progress is piecemeal, and communities that are outside the orbit of the intervention are nonetheless taking in thousands of families from the old projects and await support. Many destinations are not even in Chicago, as the southern suburbs have discovered, some to their considerable surprise. Taking a more structural or bird's-eye view is thus necessary and consistent with the critics of neighborhood effects who argue for a focus on how factors such as concentrated poverty, racial integration, residential stability, and now home foreclosures are influenced by interconnected housing and school policies, zoning decisions, economic development and banking policy, and a number of other government actions or universal forces that are external to any given neighborhood. But the internal dynamics of a neighborhood remain crucial, not the least, because external institutional actors react to them, as do nonresidents. Such a stance simultaneously respects both the "political economy" and neighborhood traditions but also critiques globalization theorists and those focused on individual choice, drawing on my view that no one level of analysis is necessarily privileged at the outset in terms of a holistic understanding of causality.

In all these potential efforts, it follows that individuals are still of concern, especially the most vulnerable among us—children. Linking investments in early child development with community context is thus an idea whose time has come. This idea complements an emerging body of scientific evidence that links children, communities, and schools (Heckman, 2006; Raudenbush, 2009; Shonkoff & Phillips, 2000). The national interventions now being promoted by the federal government in many cities, such as Choice Neighborhoods and Promise Neighborhoods, along with localized efforts such as the Harlem Children's Zone (Wilson, 2010), provide grounds for optimism that a new generation of social-level thinking for children can be integrated with a more dynamic concern with what happens when we take things to scale. Linking community-level interventions with systematic observational and ethnographic knowledge about the mechanisms of urban change seems an especially promising direction. Properly done, intervening at the community level is not only feasible but more cost effective in the long run than targeting individuals. Predicting individual behavior is notoriously difficult and inefficient, whereas as I have shown that community social structures are highly patterned over time. Ironically, then, policies seeking to promote individual development might better start not with the individual but with the social context, where inequalities at birth are already well in place.

CONCLUSION

Rethinking "What Works" Structurally

I submit that we need a new definition of what constitutes policy evaluation to complement the more holistic approach to intervention I have sketched. If social structure and ongoing neighborhood dynamics are crucial to the long-term prospects of meaningful change, they should be a required part of the evaluation of any social policy, even if ostensibly aimed at individuals or a single community. It is not enough to move residents out of Cabrini-Green or the Robert Taylor Homes and remove the physical evidence of past mistakes, or to erect new housing in their former shadows. The social fabric was fundamentally altered in unintended ways, and displaced residents are moving to other neighborhoods, many with similar problems. If left unattended, these destinations will produce new versions of concentrated disadvantage and social stigma, and in turn new feedback loops of neighborhood social reproduction.

Ultimately, then, my argument is that intervention is never in just one community, even though it was designed or described as such. Not even a program such as the Harlem Children's Zone (HCZ) can be isolated and set aside as a model for replication, as it has been in the popular press. The very concept of a "zone" implies embeddedness, and two of the mysteries of the HCZ to date is what mechanism is doing the work and whether the program can be taken to scale in other contexts. I suspect it cannot, at least not in the ways currently promoted. Once an intervention takes hold, both formal rules and informal practices change, and interconnected actions cumulate to form new structures. Even the simple act of moving to Harlem to take advantage of its community-wide benefits means that some other community was left behind and thus affected—residential mobility is never just about an individual. These kinds of extralocal effects thus need to be considered in the costs and benefits ("what works") of intervening in any one community. By considering the big picture and how it is drawn by individual actions and structural constraints alike, and by looking to the success of population-level health policies over the past century, we have the tools of ecometrics (Raudenbush & Sampson, 1999) and the theory to rigorously study these processes, intervene accordingly, and evaluate holistically. Although it may seem obvious in retrospect to bring context and history into the formal evaluation process, in practice, this is rarely done in ways that respect interlocking structures and mechanisms. A rescaled approach to policy evaluation is thus in order.

This conclusion is optimistic with respect to social policy. For no matter how much neighborhoods appear stable (and the evidence on this is very strong, as I have shown), existing continuities are not inherent but are socially reproduced in multiple ways that can be acted upon. We act on individual incentives all the time, and macronational policies are woven into the identity of the country. Hence there is nothing intrinsic about policy to prevent intervening at the scale of the community

and citywide social web while attending to the realities of individual choice. My engagement with the streets and neighborhoods of Chicago has convinced me that if we do so, we will discover the logic and power of neighborhood effects in organizing a surprisingly diverse array of everyday life.

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25

Another Border to Cross

Mexican Immigrant Families and Obstacles to Integration in the Suburbs

Benjamin J. Roth

In the past twenty years the geographic pattern of immigrant settlement in the United States has decidedly broadened, shifting from traditional gateways—ethnic neighborhoods in central cities—to places such as suburbs and small towns that have not been home to new immigrants for generations (Singer, 2004). This settlement shift has been so significant that immigrants in America's largest metropolitan areas are now more likely to live in the suburbs than in central cities (Wilson and Singer, 2011). These emerging, receiving contexts are not always welcoming to new immigrants. Indeed, Mexican immigrants, America's largest immigrant group, face significant barriers to integration in many new settlement areas where social boundaries are being drawn and redrawn along the lines of race, national origin, and legal status.

Coinciding with changes in immigrant settlement patterns is a growing concern for the fate of the children of Mexican immigrants (Portes and Rumbaut, 2001; Alba and Nee, 2003; Kasinitz, Mollenkopf, and Waters, 2002). Mexican immigrant youth are more likely to drop out of high school and get arrested than their peers from most other ethnic groups. Yet, data on the children of Mexican immigrants primarily come from large surveys conducted in urban areas such as San Diego, Miami, Los Angeles and New York (Portes and Rumbaut, 2001; Kasinitz, Mollenkopf, and Waters, 2002). Little research has focused on the adaptive pathways of Mexican immigrant youth in the new settlement areas such as the suburbs (Waters and Jimenez, 2005; Ellis and Almgren, 2009). How are these youth being received in the suburbs?

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Immigrants' receiving context has implications for their social and economic adaption to the host environment. The nation-state is the scale at which the receiving context is most often conceptualized, but there are multiple sub-national scales that merit consideration (Ellis and Almgren, 2009). At a more local scale, the receiving context can be conceptualized as the everyday places where immigrants and their families live, shop, and go to school. In contrast to federal immigration legislation—the receiving context at the level of the nation-state—local laws and policy decisions address questions of *immigrant integration* (or exclusion) rather than *immigration regulation*. Nonetheless, local authorities might be recognized as operating "by proxy" to fill the gap created by the lack of a comprehensive federal response to the growing number of labor migrants (Varsanyi, 2010; Wells, 2004). Such actions may intend to target unauthorized immigrants (those who entered the country without permission or overstayed their visa), but given the large number of mixed-status households[1] and the risk of profiling based on skin color, those immigrants or children of immigrants who are authorized U.S. residents or citizens are also impacted by local integration policies and practices. In sum, local and state governments play a powerful role in regulating the lives of immigrants, and the importance of understanding how local context matters for immigrant integration has become even more salient with the changing geography of immigrant settlement.

Studying the immigrant receiving context at the local level may create new analytic opportunities for understanding variable adaptive outcomes for Mexican immigrant youth in new destination areas. Research on new immigrant destinations has focused primarily on immigrant adults, partly because the number of immigrant youth in these places is still relatively small. However, as more immigrants continue to settle outside of traditional ethnic enclaves in central cities, an increasing number of immigrant youth will be coming of age in new destination areas such as the suburbs.

This chapter explores two factors and how they *directly* or *indirectly* influence the receiving context for immigrant youth in the suburbs: local policies and the local social context.[2] For the purposes of this chapter, *local policies* are defined as municipal ordinances and their implementation. Ordinances that directly affect immigrant families include English-only laws that restrict information accessibility. More indirect laws include housing policies—such as occupancy ordinances—that tend to impact immigrants because of the targeted manner in which they are implemented, or police practices such as roadside checks to determine whether motorists are driving with a valid license and insurance. *Local social context* concerns the extent to which immigrants experience discrimination in the places where they settle. Schools and neighborhoods are two domains that are particularly important for immigrant youth in the suburbs. Therefore, *social context* will include school policies and educational programs developed and implemented by the local school board, local leaders, and other nonprofits, as well as key characteristics of local neighborhoods, such as crime rates and the quality of housing.

SEGMENTED ASSIMILATION THEORY AND THE RECEIVING CONTEXT

Segmented assimilation theory suggests that the immigrant children of some contemporary ethnic groups are at risk of certain negative outcomes—such as dropping out of high school, incarceration, and early parenthood—that can interrupt the processes of social integration and economic mobility (Portes and Zhou, 1993; Portes and Rumbaut, 2001). Alejandro Portes and his colleagues find that Mexican immigrant youth are particularly vulnerable to following a "downward" adaptive path relative to their peers from other ethnic groups. Portes and Rumbaut (2001) explain that Mexican immigrant parents are disproportionately represented among low-skilled immigrants, and their children are particularly disadvantaged by the context where they grow up. In their model of immigrant integration, there are two factors that define the receiving context for immigrants and their families: government policies related to immigration and immigrant integration and societal reception.[3]

The first dimension of the receiving context concerns the immigration policies of the receiving government, ranging from being exclusionary toward a particular immigrant group to actively supporting the processes of social and economic integration. Exclusionary policies are those that force immigrants "into a wholly underground and disadvantaged existence" by rendering them illegal aliens who do not have permission to live or work in the country (Portes and Rumbaut, 2001, pp. 46–47). Government policies that actively encourage immigrant integration primarily apply to refugees, but also pertain to highly skilled immigrants who are admitted to fill gaps in the upper tiers of the labor market.

The second factor concerns the reception immigrants receive from the host society. Portes and Rumbaut (2001) state that race is the primary determinant of social distance between an immigrant group and the dominant group. "In America, race is a paramount criterion of social acceptance that can overwhelm the influence of class background, religion, or language" (2001, p. 47). They clarify that race "inheres in the values and prejudices of the culture" such that two individuals who look alike may experience very different treatment depending on their social context. As with federal immigration policy, Portes and Rumbaut describe societal reception along a continuum. At one extreme is a prejudiced reception. They explain that prejudiced reception is given to non-white immigrant groups and those with perceived involvement in the drug trade. At the other extreme is a neutral reception—the reception accorded to groups that are defined as mostly white.

Together these two factors shape the process of immigrant integration and help explain why immigrant groups have different economic and social outcomes depending on where they live. "No matter how motivated and ambitious immigrants are, their future prospects will be dim if government officials persecute them, natives consistently discriminate against them, and their own community has only minimum resources to offer" (Portes and Rumbaut, 2001, p. 49). Portes and Rumbaut

argue that such conditions, while directly influencing immigrant parents, also pose formidable disadvantages for the children of immigrants. Therefore, they emphasize the importance of the receiving context to the adaptive pathways of immigrant youth.

Using data from interviews with fifty-six local actors (mayors, city officials, school teachers and administrators, church staff, and other community leaders), thousands of articles from local newspapers, and Census data, this chapter will assess two Chicago suburbs as local receiving contexts for Mexican immigrants and their families.[4] These data suggest that across both factors—local policies and social context—various organizations and individuals in each city were at times welcoming and unwelcoming to immigrant newcomers from 1990 to 2010. Not all of the policies and decisions made by these actors *directly* influenced Mexican immigrants and their families, but many highlight key flashpoints when the contours of the receiving context were defined and redefined. The core argument in this chapter is that suburbs are distinct and dynamic contexts of reception where a set of individual and organizational actors—including immigrants themselves—are engaged in the ongoing process of negotiating social, political, and spatial boundaries that matter for the adaptation of Mexican immigrants and their children.

CASE STUDY DEMOGRAPHICS

There was significant growth in the immigrant population throughout Chicago suburbs from 1990 to 2010, but some places experienced a larger and more rapid increase. There has also been considerable expansion in the numbers of poor and undocumented individuals across the suburbs during this time period. However, as with rates of immigrant concentration, the growth in these vulnerable populations has been uneven across the suburban landscape. Waukegan and West Chicago, the two suburban case studies featured in this chapter, are two suburbs that experienced a more acute rise in undocumented immigrants and low-income individuals. To the extent that the intersection of these demographic changes may trigger community-level concern about immigrant integration and overall social cohesion, Waukegan and West Chicago are places where we might expect to find elevated tensions between new and established residents and a less welcoming context of reception for Mexican immigrants, many of whom are undocumented and low income.

West Chicago was established in the mid-1800s as a railroad town where several lines intersect; it is now home to a few small manufacturing firms—one of its largest employers is a popsicle factory—a mix of old and new residential developments, and a sleepy Main Street in the shadow of a tall, faded-blue water tower bearing the city's name. The 26,348 residents of West Chicago live roughly forty miles from downtown Chicago in one of the wealthiest counties in the nation. West Chicago is ten minutes west of Wheaton, the county seat and home to a number of nonprofit and public social services. On the other side of West Chicago lie St. Charles, Geneva, and

Batavia, three relatively affluent suburbs along the Fox River. One public high school serves all of West Chicago and parts of two neighboring suburbs.

With nearly 90,000 residents, Waukegan is over three times larger than West Chicago but more economically depressed. It sits atop a hill alongside Lake Michigan and boasts sweeping views of the shorefront—a resource that is tantalizingly close, but separated from the downtown area by an expressway,[5] railroad tracks, and a decaying industrial area that memorializes Waukegan's era as a regional manufacturing giant.[6] While the other large factory towns at the edge of metropolitan Chicago—Elgin, Aurora and Joliet—were able to better diversify their local economies with casinos on the Fox River, Waukegan has had to rely on service industry firms and small businesses such as bakeries, clothing stores and restaurants.[7] Compared to West Chicago, its housing stock is sixteen years older (ACS, 2006–2010 combined), its residents are less likely to be home owners (53.3 percent compared to 69.1 percent) (Census, 2010), and, on average, its homes are worth nearly $100,000 less than those in West Chicago.[8]

Recent demographic changes in West Chicago and Waukegan show increased immigrant populations, with marked increases of Mexican-origin residents (foreign- and native-born individuals of Mexican descent),[9] low-income individuals and undocumented immigrants.[10] Total population growth slowed in Waukegan and West Chicago during the early 2000s, but what growth did occur was largely attributable to the in-migration or growth of the Mexican-origin community (foreign-born and native-born Latinos who identify Mexico as their national origin). Like several other small towns ringing Chicago, the manufacturing sector and railroads facilitated the migration of workers from Mexico to West Chicago and Waukegan beginning as early as 1910. The share of Mexican-origin residents in West Chicago and Waukegan is now quite similar (47.3 percent and 43.4 percent respectively), but while West Chicago's Mexican-origin population approached 30 percent of the city's population in 1990, in Waukegan at the time they accounted for only 16.6 percent of all residents. Then, in the early 2000s, Waukegan's Mexican-origin population outpaced West Chicago's. The number of Mexican-origin residents in Waukegan grew by 25.6 percent in the most recent decade and accounted for much of the city's total population growth during this period.

Coinciding with the in-migration of Mexican-origin residents, a non-trivial number of non-Hispanic whites moved *out* of Waukegan from 1990 to 2010. Each decade the city hemorrhaged thousands of white residents such that there were 48.4 percent fewer non-Hispanic whites living in Waukegan in 2010 than there were in 1990, despite a total population growth rate of 1.3 percent. This trend was more muted in West Chicago. When the growth of the Mexican-origin community in West Chicago was at its height during the 1990s, the non-Hispanic white population *increased* by 12.3 percent. By 2000, there were roughly equal numbers of Mexican-origin residents (10,600) and non-Hispanic whites (11,000) in the city. By 2010, however, this balance in West Chicago had shifted. The non-Hispanic white population shrunk by 2.6 percent to 10,800 during the first decade of the 2000s, while

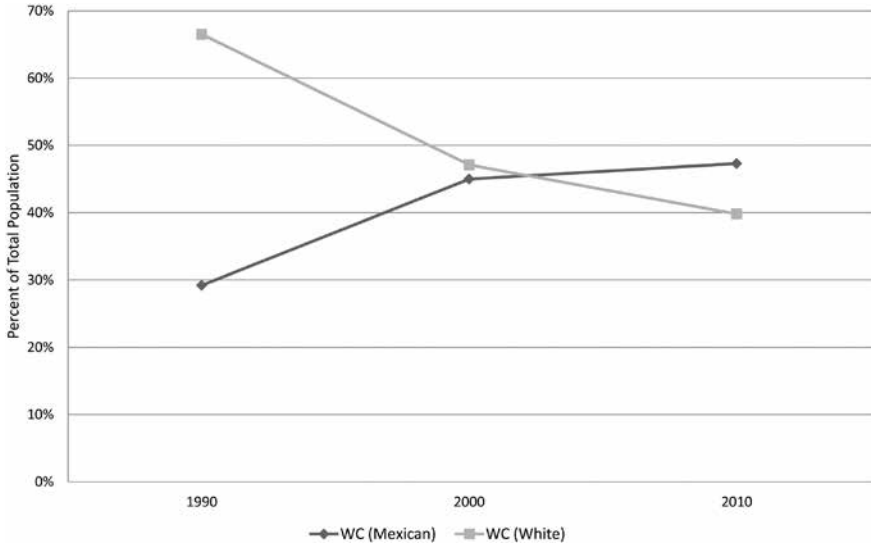


Figure 25.1. Population Change in West Chicago (1990–2010).

the Mexican-origin population continued to grow (12,800). The Mexican-origin community now represents over 47 percent of all West Chicago's residents (Latinos comprise 51.1 percent).

Both West Chicago and Waukegan have very similar percentages of immigrant residents (36.5 percent and 32.7 percent respectively), and Mexican-born residents make up the majority of immigrants in both places—they are 69.4 percent of all

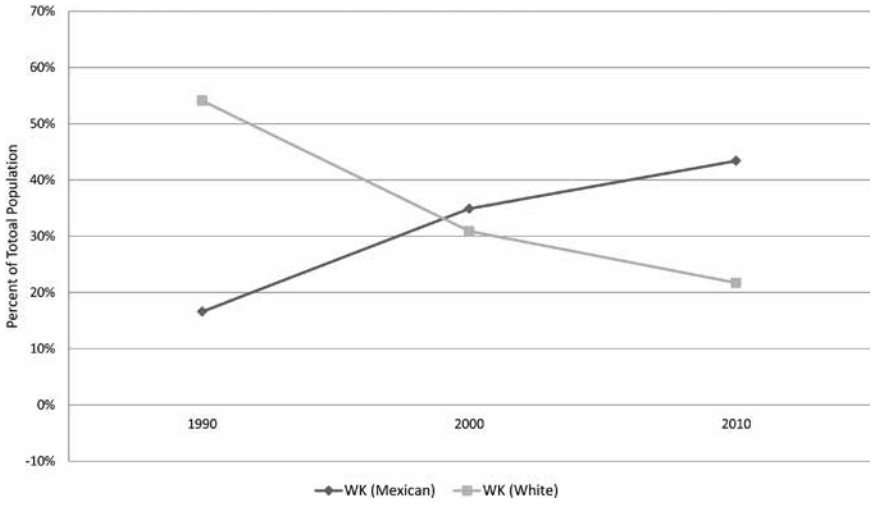


Figure 25.2. Population Change in Waukegan (1990–2010).

Table 25.1. West Chicago and Waukegan Demographics

	West Chicago			*Waukegan*		
	1990	*2000*	*2010*	*1990*	*2000*	*2010*
Total Population	14,796	23,469	27,086	69,392	87,901	89,078
Non-Hispanic White (%)	66.5	47.1	39.8	54.1	30.9	21.7
Black (%)	1.8	1.7	2.5	19.9	19.2	19.2
Latino (%)	29.9	48.6	51.1	22.7	44.8	53.5
Latino, Mexican-origin (%)	29.2	45.0	47.3	16.6	34.9	43.4
Immigrant (%)*	21.0	34.1	36.5	15.5	30.2	32.7
Immigrant, not a citizen (%)*	17.1	27.2	25.3	9.9	22.9	24.6
Poverty Rate *	7.0	9.3	10.9	9.5	13.9	13.9
Poverty Rate among Latinos*	8.8	14.8	16.7	13.0	18.0	13.9
Owner-occupied housing units (%)	55.9	67.8	69.1	53.6	56.5	53.3

Source: 1990, 2000 and 2010 Decennial Census; American Community Survey (2006–2010 Combined) where indicated (*)

West Chicago's immigrants and 72.8 percent of immigrants in Waukegan.[11] The percentage of undocumented residents in both municipalities climbed in the 1990s, and today the relative size of the undocumented population in the two cities is quite similar. Among West Chicago's immigrants, 69.2 percent are undocumented. They represent a total share of 25.3 percent of the city's population. In Waukegan, three out of every four immigrants (75.2 percent) are undocumented.[12]

Poverty rates in West Chicago have increased steadily (if slowly) the past two decades, from 7.0 percent in 1990 to 10.9 percent in the mid to late 2000s. Similarly, the poverty rate in Waukegan rose over four percentage points from 1990 to the mid to late 2000s, increasing from 9.9 to 13.9 percent. Low-income residents in West Chicago are more likely to be Latino than their counterparts in Waukegan. Of the 10.9 percent of West Chicago residents who are poor, 74.5 percent of them are Latino. In Waukegan where the poverty rate is slightly higher (13.9 percent), Latinos represent just over half of all low-income individuals (52.5 percent). The median household income for Latinos in West Chicago ($49,848) is nearly $5,000 more than it is for the average Latino household in Waukegan ($45,292), but the income gap between non-Hispanic white and Latino households is considerably larger in West Chicago ($29,500) than in Waukegan ($12,000) (ACS, 2006–2010 combined).

FACTOR #1: LOCAL POLICIES

Housing-Related Policies

West Chicago and Waukegan have attempted to shape the receiving context for Mexican immigrants by regulating and policing the homes and neighborhoods where they live through housing ordinances, redevelopment initiatives, and police collaboration with management companies in apartment complexes. In effect, these policies, practices and partnerships communicated to immigrants that they were welcome to live in certain neighborhoods but not in others. At times, they communicated that immigrants were not welcome to live in that suburb at all.

Housing occupancy codes determine the number of individuals who can safely live in a dwelling. The codes themselves are based on normative standards with no scientific basis, and have been used since they were originally designed by reformers in the early 1900s to restructure the living conditions of immigrants in the United States (Roth, 2008; Pader, 1994). In West Chicago and Waukegan, these ordinances and their selective enforcement targeted Mexican immigrant families.

Housing occupancy code violations are often brought to the city's attention because residents call city hall to complain about quality-of-life issues, such as too many cars in their neighbor's driveway. In this way, the codes themselves become a mechanism by which residents can police who is welcome in their neighborhood. Most complaints tend to happen in neighborhoods with single-family homes (rather than apartments), where the signs of overcrowding are more obvious. In Waukegan

and West Chicago, the most affordable homes are in neighborhoods with older housing stock. These are also neighborhoods where low-income Mexican immigrants are more likely to live. Many of these homes were built in the 1950s and 1960s, and tend to be smaller than more recently constructed homes. Ironically, they were built during a time when the average American family tended to be larger and a different standard was used to determine the amount of square footage a family needed to live comfortably. In other words, housing stock that "safely" accommodated large families when it was originally constructed was declared inadequate for similar-sized families when immigrants began moving into town fifty years later.

Waukegan's alleged violation of fair housing laws in 1994 provides an example of how housing policy and its implementation reshaped the receiving context. In 1994 the city had implemented an ordinance that permitted only a husband and wife, their children, and a maximum of two relatives to live in a house or apartment, regardless of the dwelling's size. The complaint filed by the Justice Department in 1996 stated that Waukegan city officials "repeatedly have expressed their animosity toward the new Hispanic residents of Waukegan, and declared that they intended to prevent Hispanics from 'taking over' Waukegan" (Civil Action No. 96-C-4996). The Justice Department alleged that the city revised and selectively applied the ordinance in order to target Latino residents. Indeed, building department records submitted by the city indicated that all of the evictions resulting from violating the family composition law were Latino households (Civil Action No. 96-C-4996). In the 1997 settlement, the city agreed to pay $200,000 in damages and fines; train employees responsible for zoning and land use to better understand Fair Housing law; and hire a bilingual fair housing counselor to handle housing complaints.[13]

A similar lawsuit was filed against West Chicago. Rather than redefine who qualifies as a family member, in November 2002 the city council passed an ordinance that redefined what qualifies as a bedroom. The new ordinance defined a bedroom as a space with four walls, at least one window, and a door that closes, thereby making it more difficult for tenants to convert kitchens and dining rooms into bedrooms. The revised housing code determined maximum occupancy thresholds by calculating the number and size of bedrooms rather than the overall square footage of the dwelling. This automatically rendered a larger number of households out of compliance with the city's occupancy code. West Chicago's mayor at the time had campaigned on the promise to reduce household overcrowding. He insisted the primary concern was safety, but one advocate for the Latino community stated that the city council was making more of an issue of overcrowding than was necessary and, ultimately, targeting Latino residents.

In *Romero vs. West Chicago* (2003), the Latino plaintiffs alleged that West Chicago code inspectors had violated their civil rights and fair housing law by discriminating against them because of their national origin. The Romeros lived in a four-bedroom home two blocks from the high school on the south side of town. Visiting the house at the time of the pre-dawn raid in June 2002 were two brothers, a sister-in-law, and Mr. Romero's parents. In November 2003, nine months after the lawsuit was

filed, the city settled with the Romeros for $100,000 in damages. The city made no admission of wrongdoing, but as part of the settlement the city agreed to hire a housing advocacy group to monitor its code enforcement practices for four years. As in Waukegan, the settlement also required the city to hire a part-time bilingual public information officer.

There have not been any fair housing lawsuits in Waukegan or West Chicago since their respective cases were settled, but West Chicago has directed its attention to the apartment complexes where many Mexican immigrants currently live. There are five large complexes scattered across West Chicago. Together they provide hundreds of units of housing, and the majority of the families who live there are of Mexican descent. Residents often refer to the city's apartments as "the ghetto," where gangs, violence, and social problems tend to originate.

There were sixteen shootings in West Chicago in 1994, and all of them were attributed to immigrant youth involved in Latino gangs. One way the city responded to the spike in violence was by slating one of the apartment complexes for demolition. In early 1995, the Clayton Street apartment complex was designated a tax-increment financing (TIF) district which would be redeveloped in the name of urban renewal. It had been the focus of a series of police stings the previous year, and one official said it "just wasn't properly designed to begin with . . . [I]t was designed to fail and that's what it's doing" (Ferris, 1995). The majority of the 125 units of housing were occupied by low-income Mexican immigrants (Gregory, 1996). The city finally decided against the plan (another DuPage County municipality had been sued recently for razing affordable housing units that were primarily home to Latinos), but not before their deliberations sparked a response from hundreds of angry West Chicago Latinos.

Another approach used in West Chicago to curb the violence of gang-involved immigrant youth was to increase police presence in the apartment complexes and schools. Residents voted to approve a referendum to hire thirteen more police officers and a social services coordinator at a cost of $1 million. With this new funding source, the police created a task force on gangs and developed a new school-based position in partnership with the local high school in order to gather information about local gangs more efficiently and interrupt their ability to recruit new members.

The West Chicago Police Department also adopted a community-oriented approach to managing the social problems in Mexican immigrant neighborhoods. This led to the emergence of Neighborhood Resource Centers (NRCs) in 1993 in the Westwood Apartments.[14] When NRCs first developed in Chicago's suburbs in the early 1990s, they were police sub-stations located in high-crime apartment complexes that aimed to improve community safety by providing preventative services.[15] The centers were partnerships between suburban police departments and apartment management companies. The latter typically provided office and program space, and both entities would meet regularly to share information about tenants.

The West Chicago complex was chosen as a site for the city's first NRC because of the social problems at the complex and its isolated location relative to services such as the public library and social service providers. The center was coordinated initially

by a sergeant from the police force until a clinical psychologist was hired to run the center in June 1994. Although the majority of the people who accessed the program were Mexican immigrants, neither of the first two directors spoke Spanish. By 2010, the city had three NRCs in as many apartment complexes serving hundreds of immigrant families and children. The social service division was run by an immigrant woman from Panama, and the director of the NRCs was a bilingual Latina. Together the two social workers built up the NRCs to be multi-service nodes which offered a range of services to immigrant families, including afterschool programs, classes for young parents, and mentoring for adolescents. They also mediated between immigrant families and the local police, schools and city hall on issues such as domestic violence, school truancy, and gang involvement.

The NRCs were some of the only community-based programs in the city of West Chicago that worked directly with immigrant youth and families. When, in 2011, two of the NRCs closed due to funding reasons and the operations of the third were significantly scaled back, no other formal social service programs were located in the city's apartment complexes aside from a small (but growing) program in Westwood funded by a local Protestant church. In the span of two decades, the City of West Chicago had transitioned from using a range of tools to police and assimilate Mexican immigrants—actions that had stirred the concern of Latino residents and advocates—to quietly removing the local programs that had eventually evolved as core supports for immigrant families. Although the program closures may have been more immediately devastating for immigrant families, there was no public outcry when the NRCs closed their doors.

Towing Ordinance

Vehicle seizure (i.e., towing) ordinances represent another type of local policy in West Chicago and Waukegan that has reshaped the context of reception. In the mid-2000s, both cities introduced or modified ordinances to strengthen the ability of police to seize vehicles operated by individuals without a valid license. As with housing occupancy codes, the language of the towing ordinance does not specify that immigrants are the object of concern, yet their implementation had direct consequences for Mexican immigrants in Waukegan and West Chicago.[16] Although the language of the ordinance is virtually identical in both places, it was received differently in the two communities. The ordinance in West Chicago passed with minimal attention, but in Waukegan criticism led to mobilization on both sides of the issue.

Beginning on May 1, 2005, the West Chicago City Council effected a towing ordinance to address the increasing number of traffic arrests due to driving without a license or with an invalid one. Before the ordinance was passed, West Chicago Police reported that they typically seized only one vehicle a month. A roadside traffic check conducted by the police the year after the ordinance's approval resulted in twenty-three vehicle seizures in four hours. The administrative penalty in West Chicago for driving without a valid driver's license is $555, not including towing and storage

feeds. Beyond the financial penalty, roadside checks unnerved the immigrant community. Such fear can interrupt daily living as well as an immigrant family's ability to access certain resources, even church. According to the Latino pastor of a Protestant Hispanic congregation in West Chicago:

> [W]e have police officers directing the traffic [outside our church on Sunday mornings], and we've heard from people, especially in [a nearby immigrant apartment complex]—they drive by, they see the police and they keep on going. They don't know that [the police are] just directing traffic.

Although it was not well received by many Mexican immigrants, the vehicle seizure ordinance in West Chicago did not provoke anything near the response that a similar ordinance sparked in Waukegan. One reason was that Waukegan's mayor at the time, Richard Hyde, was widely viewed as unwelcoming to immigrants. In June 2003 Waukegan revised a towing and vehicle seizure ordinance to allow police to impound the vehicle of anyone driving without a valid license[17] (Slack, 2008). This laid the groundwork for protracted tensions in Waukegan between city hall and Latinos and proved to be so disruptive that it attracted national attention. In 2003, the revised seizure law led to the confiscation of 6,830 vehicles and netted the city $2 million (Gibbard, 2004). During this same period, Mayor Hyde was elected for another four-year term. He received at least $27,000 in campaign contributions from local towing companies (Slack, 2008).

As complaints from Latino motorists flooded Spanish-language media, advocates and organizations rose up to argue that the ordinance and its implementation was discriminatory because Latinos were being profiled by police (Slack, 2008). In July of 2004, about one hundred people attempted to attend a Waukegan City Council meeting to protest the city's practice of unnecessarily towing the cars of people driving without a license. The city refused to let most of the protesters enter even though there were ample seats available.[18] In January of 2006, a group led by Father Jonas, a priest at St. John's, the city's largest Catholic Church, wanted to start a dialogue on how the law affected Hispanics. Waukegan officials met with him and five hundred city residents, most of them Latino, many of them parishioners. When Father Jonas asked how many people in the audience did not have a driver's license, nearly two hundred individuals stood up (Mucha, 2006).

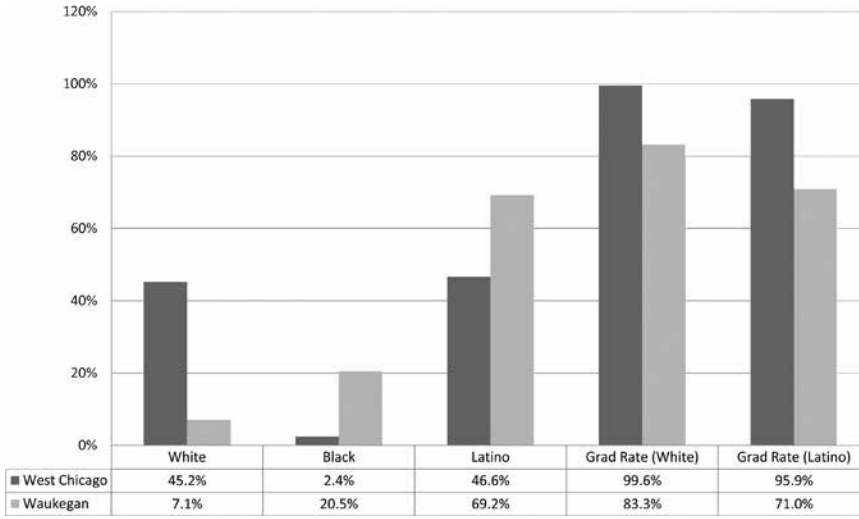
This pivotal moment demonstrated the boldness of the immigrant community, their trust in Father Jonas, and the important role of the local church in mediating social tensions surrounding the towing ordinance. It also helped to mobilize a coalition of individuals and organizations in support of the rights of immigrants in Waukegan. St. John's efforts to fight the ordinance received support through multiple grants and partnerships. In the spring of 2006 St. John's received a $25,000 grant from the Illinois Coalition of Immigrant and Refugee Rights as part of the state-funded New American Initiative program. The church also partnered with the Midwest Immigrant and Human Rights Center and Lake County United—a local advocacy organization—to improve rates of civic participation among Latino

residents. These partnerships and coalitions were galvanized the following year when Waukegan applied for the controversial 287(g) program, a partnership between local law enforcement in federal immigration officials, and again when Mayor Hyde was up for reelection in 2009. They were successful in both campaigns: Waukegan withdrew its 287(g) application and a strong showing of Latino voters elected a new mayor.

FACTOR #2: SOCIAL CONTEXT

Waukegan and West Chicago each has one public high school, and both schools have a large percentage of Latino students.[19] Waukegan public high school had over 4,250 students enrolled in 2010. Some 69 percent of the high school student population identified as Latino that year, and 8.0 percent had limited proficiency in English. Just over 20 percent of the high school students were African American, 2 percent were Asian, and 7 percent were non-Hispanic white. West Chicago's high school is roughly half the size of Waukegan's. Of West Chicago's 2,169 students in 2010, 46.6 percent identified as Latino and 45.2 percent as non-Hispanic white. Only 2.4 percent were African American. Students in West Chicago, regardless of race or ethnicity, were more likely to graduate from high school in 2010 than their counterparts in Waukegan, and the gap in graduation rates between Latinos and non-Hispanic whites in West Chicago is less than it is in Waukegan.

These statistics suggest that Latino public school students in West Chicago are considerably more likely to graduate from high school than Latino students in Waukegan, but an alternative measure of the graduation rate suggests otherwise.



	White	Black	Latino	Grad Rate (White)	Grad Rate (Latino)
West Chicago	45.2%	2.4%	46.6%	99.6%	95.9%
Waukegan	7.1%	20.5%	69.2%	83.3%	71.0%

Figure 25.3. High School Student Demographics, 2010.

Illinois calculates the graduation rate based on school completion, and it is not clear whether GED recipients are being included (Orfield et al., 2004, p. 34). This could lead to an inflated graduation rate. Furthermore, outcomes for students whose whereabouts are unknown are excluded from the equation when calculating the graduation rate in Illinois. Illinois state law allows school officials to "disenroll" students who are at least sixteen years old if they are not on track to graduate by age twenty-one (Orfield et al., 2004, p. 38). This means that Latino youth who drop out of school may not factor into their school's calculation of the graduation rate if they were "pushed out" due to bad grades or truancy.[20]

Alternative calculations of the graduation rate yield a very different picture of student attainment in the two cities, but particularly for Latino students in West Chicago. Swanson's (2009) method of calculating graduation rates, the Cumulative Promotion Index (CPI), suggests that the graduation rate for *all* students (not just Latinos) in Waukegan is 47.0 percent.[21] West Chicago's is 62.9 percent, which is below the state's requirement of 66 percent for Adequate Yearly Progress (AYP) (author's calculations).[22] The differences are even starker when the CPI is disaggregated by race (see figure 25.4). In Waukegan in 2010, the graduation rate among non-Hispanic white students was 74.7 percent, while for Latinos it was 36.7 percent. According to the CPI, 55.5 percent of Latino students graduated from West Chicago's high school in 2010 compared with 88.8 percent of their non-Hispanic white peers. The graduation gap between Latino and white students in both places is over 30 percentage points when using the CPI. Although Latino public school students in West Chicago are still more likely to graduate from high school than those in Waukegan according to the CPI, the graduation gap in West Chicago is now much larger. This suggests that Latino students in both schools face significantly more obstacles to graduation than their white peers.

Student performance on standardized reading and math tests further calls into question the assumption that Latinos in West Chicago are outperforming those in Waukegan. In fact, in 2010, Latino students in both high schools were about as likely to fall short of state standards in reading and math. In West Chicago, 78.4 percent of Latinos failed to meet state standards in reading in 2010 compared with 26.7 percent of non-Hispanic white students. A similar gap existed that year in math. In Waukegan in 2010, 79.5 percent of Latino students fell short of state reading standards, and 79.7 failed to meet standards in math. Non-Hispanic white students in Waukegan did considerably better (45.1 percent fell short of the standard in reading and 40.0 on math).[23] Clearly, even though Latinos in West Chicago are more likely to graduate from high school (regardless of the measure), they are not performing any better on state standardized tests.

Despite these similarities in Latino student performance, West Chicago has a larger percentage of high-performing students that inflate the performance of the overall student body. There are large disparities in both schools between white and Latino students in terms of graduation rates and test scores, but Waukegan's high school has drawn more attention for underperforming. While this attention has

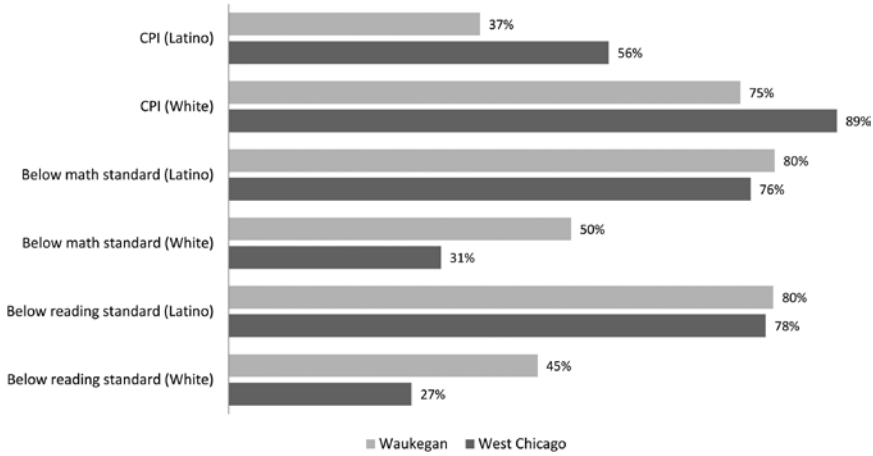


Figure 25.4. Alternative Measures of Educational Performance and Attainment, 2010.

not been positive, it has catalyzed advocates, providers, philanthropists, and other individual and organizational actors to intervene. In effect, there are more resources for immigrant youth in Waukegan than there are for those in West Chicago. West Chicago is also invested in improving its image relative to other high-performing suburban schools in neighboring municipalities, but the focus has been more on issues such as bilingual education than on large-scale systemic interventions as in Waukegan.

Bilingual Education, Dropping Out, and Alternative Programming

In 1993 West Chicago high school won a prestigious award from the U.S. Department of Education for its teaching methods, and a year later *Hispanic Magazine* recognized the high school as one of the top five in the nation to successfully met the needs of Hispanic students (Hlotke, 1994). Despite these awards, incorporating Mexican immigrant youth into West Chicago's educational system has proven challenging and at times controversial.[24] Whereas Waukegan has developed a wide array of alternative programming useful for all immigrant youth (first and second generation), the debate in West Chicago has been primarily focused on Mexican immigrant youth with limited English proficiency in an attempt to close the achievement gap between Latino and non-Hispanic white students. Latino students in West Chicago met standards only 33 percent of the time in 2007, falling short of the 55 percent minimum, while non-Hispanic white students exceeded standards by 8 percentage points. West Chicago's superintendent stated that the gap was due to a "language barrier" and "cultural issues" among Mexican immigrant students (Shenoy, 2007).

The same year that West Chicago's high school failed to meet state standards, the district's bilingual education program came under fire by school board members. Al-

though the bilingual program was considered one of the most well-developed in the state, school board president Tony Reyes called for significant changes to its structure. Reyes was the first Latino on the board, and the only Latino in 2007. Based on his experience growing up with immigrant parents in Texas, immigrant youth need to be immersed in English-only classrooms in order to learn "proper" English. From his perspective, West Chicago's bilingual program insulated limited-English proficient (LEP) students from English-only mainstream classes for longer than necessary. Reyes warned that the bilingual program "coddles" LEP students and makes it more difficult for them to learn English.[25] He argued that his position on bilingual education is in the best interest of LEP students, the school and the city. According to Reyes, better English translates to better test scores, and better test scores ultimately improve the district's "marketability." Reyes's comments ignited a heated debate among teachers and community leaders in West Chicago that has not been entirely resolved.[26]

The impact in West Chicago is that the needs of Latino youth have been conflated with the unique challenges of educating LEP students. Indeed, other factors—such as legal status—are never mentioned by school officials, even though this is a significant issue for Mexican immigrant families in the city. A school social worker at West Chicago high school stated that he sees many Mexican immigrant students who have had a family member deported: "These students often come to me seeking advice on how to get a job that earns money quickly. When I check their academic records, it's not unusual to see an increase in absences, or a drop in grades . . . They don't always share that with the school, and I wish they would because there are a lot of resources out there" (Ortiz, 2011).

In Waukegan, by contrast, most school board and media attention to issues of education has focused on the poor performance of the high school in general, rather than the deficit of immigrant youth in particular. One approach to addressing the high school's poor performance has been to provide low-income minority youth in Waukegan with a new school option. To this end, four religious congregations and a coalition of lay people in Waukegan opened a Catholic college preparatory school in 2004 with the goal of serving Waukegan's Latino and immigrant youth.[27] Four years after the parochial school opened, another coalition formed to propose a charter school to combat the high drop-out rate at the public high school. The coalition of social service agencies, churches, mosques and synagogues planned to underwrite the cost of building the school, but under their plan the public school district would need to pay for operations. After a tense public hearing conducted by the Waukegan School Board in 2008, the charter school proposal was voted down. An estimated 1,500 community members were present.

One reason why the School Board voted to reject the charter school proposal was due to structural changes scheduled to roll out in the public high school in the fall of 2009. The small learning communities initiative represented one reason why some people who opposed the charter thought it was unnecessary. In keeping with the popular small schools movement in other large districts, the small learning communities would break up students into nine groups of 400 to 450 (Zahorik, 2008).

The model assumes that breaking up large schools into smaller communities will improve educational performance and graduation rates because learning is enhanced in more intimate environments characterized by stronger student relationships with teachers and other students. The model has not been operating long enough to determine its effect on dropout rates, but not everyone is pleased with the new structure. One elected official stated that the new model is a "college machine" that forces a one-size-fits-all program onto a student population that would benefit from more options, such as a strong vocational program. He stated that it is difficult to "change a culture" of dropping out of high school, referring specifically to Latinos, and suggested implicitly that the high school is doing little to change that.[28]

A third approach to the poor performance of Waukegan's public high school has been to develop alternative educational pathways for students who have dropped out or who are at risk of doing so. The district's Alternative Operational Education Center (AOEC) is the primary alternative pathway in Waukegan.[29] The AOEC has been in operation since 1999, and is located in a large, three-story red brick building that was constructed in the early 1900s as Waukegan's first high school.[30] Previously known as the Career Academy, the AOEC has evolved over time to meet the needs of nontraditional students in Waukegan, many of whom are Mexican immigrants. Administrators at the AEOC take pride in the fact that their program provides immigrant youth with a second chance. On occasion, this means bending district rules in order to make sure they are supported. For example, the school social worker will sometimes pick up students for school if they need a ride, and they will allow students to stay enrolled even if they are not necessarily on track to graduate by age twenty-one.[31]

Although graduation rates for Latino (and immigrant) youth are a concern in Waukegan, many youth are doing well in school and continuing on to college. One way that the school structure is actively supporting these students is through several college readiness programs. The high school's College Studies Program (CSP) is the largest of these programs.[32] CSP—now two of the nine small learning communities—provides additional and more rigorous classes for approximately nine hundred advanced students. The EXCEL Program and the Kent Fellows Program are two other programs at the high school designed to help students graduate and prepare for college, but they are much smaller in size. The EXCEL Program works with low-income students to help them prepare and apply for college during their senior year. This ten-month program works with twenty students each year. The program includes a summer internship (between junior and senior year) and the opportunity to take classes with Robert Morris University, so students finish high school with eight college credits. Participation in the program is free, but only individuals with a Social Security number are accepted. In 2011 over 140 students applied. Although the program received a 20 percent funding increase and a $10,000 grant from a local company, there is only funding for thirty applicants.[33]

The Kent Fellows Program (KFP) partners with Waukegan high school to serve the top 10 percent of students who have the potential to attend a selective college but

lack the resources or support to do so. Unlike EXCEL, KFP is funded completely by one private foundation. It was started in 2001 by a wealthy co-founder of a private investment firm in a nearby suburb. In 2002 the program forged a partnership with Waukegan high school to provide academic support and enrichment programs for a select group of students called "Kent Fellows."[34] By 2011, the program was working in five additional high schools in Lake County (including St. Martin de Porres).

KFP provides comprehensive academic and college counseling in order to ensure that Kent Fellows register for and perform well in the high school classes that will best position them when applying for college. KFP pays for college visits, a summer camp, field trips to cultural events, and a $10,000 scholarship to college. KFP has an office in Waukegan public high school where scholars can access a private computer lab, get some free snacks, and find a quiet place to study. The program is designed to create a social and physical bubble to protect scholars from the chaos that students experience in many other parts of the school. Kent staff are active advocates for their scholars, and will meet with teachers, administrators and the school board to request that better classes be offered, the best teachers are instructing, and their students have access to the resources they need to be prepared for the rigor of an elite college.

Kent has invested more human and financial resources in Waukegan than in any other school they partner with, yet their program is not as successful as it is in other schools. The primary reason is that the high school and middle schools have proven resistant to change, and there is an unwillingness to adapt to KFP's needs. This has made it more difficult for KFP to accomplish its goals with students. For example, KFP's administrators have found in other suburbs that the program is much more effective at winning trust with immigrant parents and their children if they can get involved earlier on in the lives of the students. Yet in Waukegan they continue to encounter road blocks with the superintendent and administrators from the middle schools. As a result, KFP has restricted their program to tenth through twelfth grade rather than including eighth and ninth grade students as they have in other districts.

In sum, relying solely on high school graduation rates, West Chicago would appear to be more adept at integrating Mexican immigrant youth than Waukegan. However, Waukegan has a more developed set of organizational supports for low-income immigrant youth than West Chicago, including a large alternative school and several college-bound programs. Programs such as the Kent Fellows serve a small number of students, but they still provide an opportunity for Mexican immigrant youth that their counterparts in West Chicago do not have.

CONCLUSION

Portes and Rumbaut's (2001, 2006) model of the receiving context suggests that Mexican immigrants will face structural obstacles when integrating into the social, political, and economic places where they settle, but their model must be scaled

down to account for differences in reception across local contexts. Using their model as an analytic framework, I have shown that the receiving context can—and should—be analyzed at the local level in terms of local policies and the social context. This comparative analysis of West Chicago and Waukegan illustrates that these two suburbs have much in common. Both have undergone more "hostile" periods (to use Portes and Rumbaut's term), including the *Romero* case in West Chicago and the debate in Waukegan over its towing ordinance. Yet this analysis also shows how similar social tensions can be quietly dismissed or vehemently opposed in ways that reflect key differences in the receiving context. The towing ordinance in both places was virtually identical on paper, for example, but in Waukegan it helped to mobilize and politicize the ethnic community, develop new coalitions among a range of organizations, and bring in additional resources (such as grants) from outside Waukegan to support local programs.

The divergent ways in which the towing ordinance was resolved in West Chicago versus Waukegan illustrates two key structural differences of the suburbs themselves. The first factor is size. Waukegan is three times larger than West Chicago, with many more immigrants who can be mobilized for a social action campaign. The second factor is the nonprofit infrastructure and the presence of immigrant organizations. These entities made it much more possible for immigrants in Waukegan to efficiently and effectively combat the city's towing ordinance. Later, a similar coalition effectively challenged the city's application for 287(g), an agreement between federal immigration officials and local law enforcement.

Thus, this analysis has made it clear that local organizations can mediate between immigrants and a hostile reception in ways that fundamentally alter the opportunities for integration available to immigrants and their children. This is confirmed by other scholars who have emphasized the role of local organizations in shaping and reshaping the context of reception (Marrow, 2011; Lamphere, 1992). This study provides evidence that mediating organizations in immigrant suburbs do not necessarily have to be ethnic organizations—entities run by and for immigrants. Therefore, researchers should both have a multi-scalar understanding of the receiving context (sub-national and national) and broadly conceptualize the role of local organizations in shaping the receiving context in immigrant suburbs.

This study underscores that the factors in Portes and Rumbaut's model are dynamic at whatever the scale they are conceptualized. Just as federal immigration policy has evolved over time, both Waukegan and West Chicago are receiving contexts for Mexican immigrants that changed from the 1990s to 2010. These changes have happened across different periods and at different rates, and they have not occurred "naturally." Rather, they have been negotiated by a set of individuals, organizations and other stakeholders, who are operating in the midst of a larger economic and political context over which they have little (if any) control. That the receiving context is dynamic is grounds for cautious optimism. Both cities are places where the terms of integration have largely improved for Mexican immigrants since the 1990s, but not all aspects of these places are welcoming to immigrants. Furthermore, the

attendant factors shaping the receiving context for immigrants can change yet again, perhaps in ways that are more hostile to Mexican immigrants and their families.

With this possibility in mind, and considering the importance of nonprofit organizations to reshaping local receiving contexts, it is critical that public policy supports and expands the capacity of immigrant-serving organizations in the suburbs. One way that local governments can support such organizations is by channeling financial resources, such as Community Development Block Grant monies, to these entities (de Graauw, Gleeson, & Bloemraad, 2012) or by providing them with free or low-cost office space in schools and park district buildings.

Policy intervention is also needed to provide additional supports for Latino immigrant students. School boards and other elected officials must have a thorough understanding of the achievement gap between Latino immigrant students and non-Hispanic White students in immigrant suburbs. Even in higher-performing schools such as West Chicago's, Latino immigrant youth are at risk of dropping out. It is alarming that this largely goes overlooked because of the way that the drop-out rate is calculated. Greater transparency and a more thorough accounting for the educational attainment of immigrant youth is needed so that policymakers and practitioners alike can better track students and provide them with the supports they need to graduate. Officials also need to encourage the development of progressive college-bound programs such as EXCEL and the Kent Fellows Program, but these programs are not a substitute for more radical reforms that are needed throughout the primary and secondary schools in places like West Chicago and Waukegan. More research on schools across immigrant suburbs needs to identify a set of best practices so that educators can better adapt their curriculum and programming to accommodate Latino immigrant youth.

The nation-state is not an irrelevant level at which to understand the receiving context for immigrants, but the changing geography of immigrant settlement suggests that a higher-level assessment of the receiving context may overlook critical factors closer to the ground. These factors may enable policymakers and practitioners to more effectively support the processes of immigrant integration. Understanding how "the local" matters for immigrant integration is becoming increasingly important. In the absence of enforceable federal laws to help local governments manage presumed "illegal" immigrants who are settling in their communities, local authorities are using other legal means to define who is welcome and who is not, including local ordinances on day labor, housing occupancy restrictions, and driving without a license (Varsanyi, 2010; Mitnik & Halpern-Finnerty, 2010; Marrow, 2009; 2011). These local-level decisions influence the lives of immigrants, as well as the opportunities for future success available to their children.

Without strong immigrant-serving organizations and schools in immigrant suburbs, the children of low-income immigrants are at risk of not acquiring the human capital necessary to be socially mobile and competitive in the labor market (Portes and Zhou, 1993). In short, without the organizational infrastructure and the political will to welcome immigrants, many of these suburbs are doing little to facilitate

immigrant incorporation, and some may be impeding it. Therefore, the long-term social and economic implications for the children of low-income immigrants in these suburbs are worrisome. While some immigrant youth are able to leverage resources such as the EXCEL program to overcome obstacles to high school graduation and the transition to college, many others are disconnected from school, dropping out, and working low-wage jobs.

There are very few studies of immigrant youth and social mobility in the suburban context, yet immigrant settlement patterns suggest that the number of immigrant youth in these places will continue to increase. Therefore, more research is necessary to better understand how local policies and the social context in immigrant suburbs are shaping the processes of incorporation. Attention should be given to the size, organizational infrastructure, and socioeconomic diversity of these places, as well as the historical factors that have influenced the contours of these suburbs. Comparative studies of different types of suburbs are needed, as well as comparative studies of different national-origin groups within the same suburb. Research should explore how local organizations are adapting to the changing demographics of the suburbs and mediating between immigrants and local authorities—city hall, schools, policy, and more—to facilitate the process of social and economic incorporation. Finally, we need to better understand the experiences of immigrant youth themselves and the strategies they use to overcome structural barriers to social mobility in the suburbs. As they are, these barriers in the suburbs represent yet another border that immigrant families must negotiate before social and economic incorporation is possible.

NOTES

1. Mixed-status families consist of at least one unauthorized immigrant and one U.S. citizen or immigrant otherwise authorized to be in the U.S. Passel and Cohn (2009) estimate that there were 8.8 million individuals living in mixed-status families, which they more narrowly define as at least one unauthorized immigrant parent and a U.S.-born child.

2. There are many factors that influence local receiving contexts. Portes and Rumbaut (2001, 2006) also emphasize the role of the ethnic community—except for Mexican immigrants, whose ethnic communities are not typically class-diverse. Other factors include a broad range of historical, economic and political considerations that are beyond the scope of this project (Alexander 2003). This chapter uses the model provided by Portes and Rumbaut (2001, 2006), but other immigration scholars have arrived at similar conclusions about the receiving context and which factors matter for immigrant integration at the *local* level. For example, Alexander (2003) refers to a cluster of policies and practices as 'local migrant policies,' which he defines as those policies that influence the local conditions for immigrant integration: these include workplace and housing conditions, social services, education and English-language resources (Alexander 2003).

3. A third factor, the ethnic community, also determines whether the overall receiving context is hostile or welcoming toward immigrant newcomers. This is an important factor and merits the attention of a chapter on its own.

4. Data for this paper are based on interview conducted from November 2010 to October 2011 with fifty-six adult individuals who work directly with immigrant youth in the case study suburbs or who create policies that influence the environment where these youth live. Adult informants included local elected officials, school administrators and teachers, nonprofit executive directors, clergy, police officers, and adult community members. All interviews were transcribed, then coded and analyzed using nVivo, a qualitative data analysis software. Newspaper articles were collected using LexisNexis. Boolean searches for articles on immigration from Chicago's largest suburban paper yielded over four thousand hits. Articles were organized by topic, and read multiple times. Key themes emerged through the analyses of both interview and archival data.

5. The four-lane highway that runs between the harbor and downtown ends 1.5 miles to the north because the state never finished it (*USA Today*, 12/12/07).

6. Waukegan was home to numerous industries beginning in 1890 due to its proximity to Lake Michigan and access to Chicago's railroad lines. A sugar refinery and barbed wire factory opened in the 1890s, and the wire factory eventually became part of U.S. Steel in 1901. The demand for barbed wire grew along with the expansion of the railroads, one of the first markets for the product. Railroad companies used it to line the tracks, one way to appease ranchers who worried that the trains would kill their cattle who might wander across the track (4/27/10). The wire company built housing for its workers which became the city of North Chicago in 1895, a high-poverty municipality along Waukegan's southern boundary (1/14/98). As the steel industry grew, so did Waukegan's population. It increased from four thousand in 1890 to sixteen thousand by 1910, fed by the influx of immigrant workers from Eastern Europe and Scandinavia. After World War I African American laborers were recruited from the South to work in the factories, which partially explains why the area has a much larger African American population than surrounding suburbs. By the 1950s the wire mill was considered the world's largest, and Waukegan was a thriving industrial town. This period of success was short-lived, however. The plant closed in 1979, and Waukegan's economy has never quite recovered.

7. One of Waukegan's greatest economic assets is the Lake Michigan shoreline, and the opportunity to redevelop it has been one beneficial byproduct of deindustrialization. After Outboard Marine Corporation (OMC) closed in 2000, Waukegan's city council voted to approve a $33 million TIF district that included OMC's old factory site, about 110 square acres of prime lakefront property. Although the lakefront land to the east of downtown has enormous development potential, it has been scarred by Waukegan's industrial past. Waukegan Harbor is contaminated by PCBs—it was declared a Superfund site in the 1980s—and the public beach is difficult to access, located at the end of a long service road that wends its way through the lakefront's aging industrial park. Waukegan's elected officials have proposed a variety of plans to develop the beachfront over the years, but progress has been slow. One hurdle is that three remaining factories do not plan to leave. The three factories have been in operation for generations and employ roughly two hundred people, a small remnant of the thirty-five thousandworkers who used to be employed in Waukegan's lakefront factories. This creates a dilemma for the city: either redevelop the lakeshore and evict three profitable (if small) employers, or further delay (or fundamentally rework) plans for redevelopment to preserve tax income and jobs provided by these companies. Unfortunately, neither option offers any guarantee that Waukegan will remake itself once again into a strong and stable economy.

8. The median value of owner-occupied housing units in West Chicago was $260,500 in the latter half of the 2000s. In Waukegan the median home value was $165,200 (ACS 2006–2010, combined)

9. I use the Census term "Mexican-origin residents" here to include a broader swath of the Mexican ethnic community. Rather than merely focusing on Mexican immigrants, the focus here shifts to Mexican immigrants and their native-born children.

10. The respective Latino populations in West Chicago and Waukegan each increased by over 150 percent during the 1990s. In West Chicago, the Latino community grew by 158.3 percent to over 11,400 residents by the 2000 Census. Similarly, the number of Latinos in Waukegan expanded by 150 percent during that decade to nearly forty thousand. By 2000, Latinos in both places hovered at around 45 percent of their respective city's population, although in terms of national origin the Latino community in Waukegan was more diverse than in West Chicago. A Latino was more likely to be of Mexican origin in West Chicago where 92.5 percent of all Latinos have roots in Mexico. The next largest Latino sub-groups—Cubans and Puerto Ricans—each represented 1.3 percent of the Latino community. In Waukegan 81.1 percent of all Latinos were of Mexican origin in 2010. Just over 6 percent were of Puerto Rican descent, and 7.7 percent had roots in Central America, primarily Honduras (4.9 percent).

11. There are several other national-origin groups with more than a 2 percent share of the foreign born: immigrants from Honduras (5.6 percent in Waukegan), Cuba (2.8 percent in West Chicago), and the Philippines (close to 6 percent in both places). Since 2000, West Chicago's immigrant population has become more diverse in terms of national origin. The number of Mexican immigrants in West Chicago has shrunk by 6.8 percent since 2000 while the number of Asian immigrants has grown by over 240 percent (ACS 2006–2010 combined). The diversity of Waukegan's immigrant stock has remained comparatively stable during this period.

12. In terms of the racial diversity of the non-immigrant community, Waukegan is more diverse than West Chicago. Although the number of African Americans in West Chicago has increased since 1990, they still number fewer than three hundred residents (less than 3 percent of the total population). In Waukegan, however, African Americans have represented just over 19 percent of the population since the 1990s. Although their absolute numbers dipped slightly since 2000, over sixteen thousand African Americans currently live in the city. This is 12.5 percentage points higher than the share of African Americans in Lake County (6.7 percent). West Chicago, by contrast, has a slightly *lower* percentage of African Americans than Dupage County (4.5 percent).

13. Other municipalities take their cues from Waukegan's case. But the cost of losing (non-immigrant) residents who move away because they no longer tolerate the lack of enforcement may be more than the cost of a fair housing lawsuit. An article in 1999 about Elgin makes exactly this point. A group of residents organized in Elgin to keep close tabs on overcrowding in the city and report it to inspectors. The group, Solutions to the Overcrowding Problem (STOP), argue that code inspectors ought to be more aggressive.

14. West Chicago opened its first NRC in December 1993 in a large apartment complex a mile north of downtown. The center was proposed following a community needs assessment conducted by the DuPage Prevention Partnership, an independent organization located in Wheaton. The report identified key problems such as gang activity, alcohol and drug use, unsupervised children, and disorderly conduct in the apartment complex.

15. The first NRC opened in the suburb of Rolling Meadows—located in northern Cook County—in 1991. The program was an attempt to address the rising incidences of gang-related crime in a predominantly Hispanic apartment complex. The largest circulating suburban newspaper in Chicago described the Hispanic neighborhood as a place where "roving groups of [immigrant] youths wander the streets at night, drinking beer and picking fights.

Prostitutes go door-to-door, and drug dealers set up office on street corners, across from gangs that keep watch over their territory. During the day, children run around the largely Hispanic community when they should be in school. There are times police will enter the area only when armed with nightsticks and shields. The city's suburban neighbors had a nickname for Rolling Meadows. They called it Ghetto Meadows and Rolling Ghettos. Many of the immigrant youth I interviewed also referred to West Chicago's apartments as "the ghetto" or "the hood," and adult respondents often highlighted that current social problems in West Chicago are largely associated with the families that live in the apartment complexes.

16. The state of Illinois does not give driver's licenses to undocumented immigrants. The only states who do so are New Mexico, Utah and Washington. These states are reconsidering the policy (see http://www.bostonglobe.com/news/nation/2012/01/27/immigrant-driver-license-debate-intensifies/2fQzxVivq7eBC7IlrT3FVL/story.html) even while law enforcement authorities in other places, such as Los Angeles, are advocating for such a policy (http://latimesblogs.latimes.com/lanow/2012/02/lapd-chief-backs-drivers-licenses-for-illegal-immigrations.html).

17. The law states that drivers pulled over without a license will have their car impounded. The car can be retrieved if the owner pays a $500 fine, a $150 towing fee, and a $25-per-day storage fee are paid within thirty days. Unless the owner can pay the fee, the car is sold or demolished.

18. With the support of MALDEF a group of Latino residents sued the city of Waukegan in U.S. District Court in Chicago for violating their right to free speech. After some waffling, the court determined that the case against the city was moot. The Waukegan police and the city denied any wrongdoing.

19. When "Latino" is used in this section the term refers broadly to all youth of Latin American descent because the school data do not allow for finer analysis of Latinos by ethnic group. Still, as explained above, the Census data for both cities indicate that the majority of Latinos in these places are of Mexican ancestry.

20. This was the experience of several immigrant youth in this study from both West Chicago and Waukegan.

21. The CPI understands high school graduation as a *process* rather than an event. "This indicator measures the percent of 9th graders who complete high school on time with a regular diploma, given the schooling conditions prevailing during a particular year" (Swanson 2009, p. 11). See Swanson (2009) for a description of the methodology.

22. Author's calculations using data from the Illinois Report Card and the National Center for Educational Statistics.

23. There is considerable concern in Waukegan over the poor performance of the public high school. The high school failed to meet federal No Child Left Behind (NCLB) standards in 2004. In Illinois, NCLB standards determine adequate yearly progress (AYP) as measured by student performance on the Prairie State Achievement Exam (PSAE). AYP status heavily influences federal funding to schools, and is based on outcomes for the entire student body as well as population sub-groups such as those determined by race/ethnicity, low income, and English-language proficiency (2/22/07). Only 29 percent of Waukegan high school students met or exceeded standards (2/15/05). By 2010, the schools AYP status had not improved significantly, and Latino youth were not performing well.

24. Relative to national dropout trends in the 1980s, Latinos at West Chicago's high school were ahead of the curve. By 1989, the high school's dropout prevention program had been in operation for three years, and the Latino dropout rate was improving. Coordinated by a Mexi-

can immigrant who had graduated from the high school, the grant-supported program had reduced the dropout rate among West Chicago's Hispanic students from 30 percent in 1986 to 14 percent in 1989. The program coordinator, Maria-Luisa Dominguez, faced challenges similar to those described by teachers and staff over two decades later: students are expected to work full time to support their families, and immigrant parents do not necessarily understand the U.S. education system.

25. This was not the first time that Reyes tackled the issue of English-language acquisition in West Chicago. Six years earlier in response to the lack of Hispanic participation in a city-wide survey, Mayor Fortner convened a diversity program town hall meeting. Seventy individuals came to the meeting—half were white, and half were Latino. The city hired Tony Reyes as a diversity consultant to facilitate the meeting which, according to local Hispanic advocate Tom Tawney, was overly polite and politically correct. The meeting, conducted in English, yielded the opinion that the language barrier was a significant factor contributing to the social gap between Anglos and Hispanics. Reyes became D94 board president the following year.

26. One administrator in the high school's bilingual program suggested that Reyes has little knowledge of how the multi-phase bilingual program operates. She clarified that in their first year in school, immigrant youth take math, science and social studies in Spanish in the morning, and spend the second half of the day learning English. By their second year all classes are in English with minimal Spanish translation. Additional translation support is provided in the third and fourth year if necessary. The bilingual program was successful by all measures, she argued, and Spanish-speaking students were making steady improvements on standardized test scores. Similarly, an elementary school teacher, Sal Tamayo, responded harshly to Reyes's statements. He referenced research on bilingual education that contradicts Reyes's assumptions about the time necessary for LEP students to master English. Even the Regional Counsel for MALDEF wrote a letter to the editor of the *Daily Herald* criticizing Reyes for his comments. He argued that Hidalgo County's "sink or swim" approach runs counter to the Supreme Court's decision in *Lau vs. Nichols*, and a program that attempts to accelerate the mainstreaming of LEP students should be based on sound research rather than personal experience.

27. This was the first new Catholic high school in Lake County since the early 1960s.

28. He stated that the point of light for students in Waukegan is St. Martin de Porres. In his account, St. Martin de Porres is successful because of the strong work training it provides students. But he argues that more needs to be done about the quality of the high school. The future of the city depends on it.

29. The Ombudsman Program is another option, but it serves a much smaller number of students. Ombudsman is a for-profit educational program in Waukegan designed to provide an alternative pathway for students who are at risk of dropping out. The AOEC will sometimes refer students to Ombudsman who are gang involved—and many Ombudsman students are reportedly in gangs—although youth from the regular high school can also get referred directly to Ombudsman. Ombudsman is a Nashville-based company that operates schools across the country. In metropolitan Chicago, Ombudsman is mostly located in the suburbs. The company has eighteen sites in Chicago's suburbs and only two in the city of Chicago. The program in Waukegan offers computer-assisted instruction in a strip mall across from a large apartment complex.

30. There is a plaque outside the front door commemorating graduates who fought in World War I.

31. The environment at the AOEC is personable, and the administrators seem to know many of their students quite well. This approach seems to work well with most of their students, and

others outside of the AOEC are aware of its success. The founders of St. Martin de Porres high school approached administrators at the AOEC before launching the new school. They wanted to learn about the AOEC's approach to working with students who do not do well in traditional school settings. According to the AOEC's assistant director, now St. Martin de Porres sends their students who are doing poorly to the AOEC.

32. In making the case for the charter school, the Lake County United coalition suggested that CSP and St. Martin de Porres are the only two "strong, effective college preparatory programs" in Waukegan (http://www.lakecountyunited.org/pdf/education/WaukeganColPrep.pdf).

33. Although the school is supportive of the Shine program, it provides no resources—other than a small space in the library—or staff. The director is working to build a more robust list of corporate sponsors to enable more students to enroll in the program and to find other internship possibilities. The founder and director of the program, a previous employee and now board member at YCC, applied for the original federal grant that now funds Shine. Sustaining and expanding the program is a burden that rests squarely on his shoulders. "If I don't go and talk to these corporations," he said, "no one will."

34. From the Kent Fellows website.

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The Relationship between Mass Incidents and Social Inequality in the Social Transformation of China

Jing Sun, Nicholas Buys, and Xinchao Wang

The purpose of this study was to examine the association between income inequality and social resentment in Chong Qing, China. We hypothesised that (1) material deprivation, such as low income, is significantly related to social resentment, and (2) the capability of government administration, public affairs management and public services are significantly related to a high frequency of social incidents.

Methodology/Approach

A cross-sectional study design was used to collect data from 465 residents and 1,924 public servants in Chong Qing city. The resident participants were randomly selected from a list of residents aged eighteen years and over, and public servants were randomly selected from a list of public servants who worked in government from village level to municipal level. For the residents sample, the main outcome measure was social resentment. Social resentment is defined as people's discontent about social inequality and was calculated from seventeen questions clustered into four dimensions of discontent: (1) inefficient government governance and management problems; (2) public affairs problems including difficult transportation, poor environmental health, poor education system and medical service; (3) social insecurity; and (4) anxiety about possible job loss and layoff.

Findings

Poverty and its accompanying social inequality, government management and public services are the key determinants of the occurrence of mass incidents and its outbreak into violent and large-scale mass incidents.

Research Implications

The present study suggests that there are side effects and social harm from mass incidents. On the other hand, such incidents can have a positive effect on social development through opportunities to engender social and political reform as well as provide a release for accumulated tensions and grievances.

Social Implications

In the absence of the likelihood of any immediate resolution of deep-seated social injustice in China, the results of this study suggest the need to establish a more effective government management and public services model to develop effective prevention strategies to prevent mass incidents developing from disputes to large-scale violence and social upheaval. In this context it is suggested that management and governance mechanisms that include an 'interests expression mechanism' should be established, a specific agency to coordinate efficient responses to mass incidents and better communication channels between government instrumentalities and the public to address concerns.

Originality/Value of Paper

This study is the first in its kind to use a large quantitative research method that provides analysis on the causes and determinants of mass incidents in China, and thereby inform more effective public health prevention models to understand and prevent such incidents.

Commencing in the 1990s, the Chinese economy has progressively transformed from a planned economy to a market economy. Despite this rapid economic development, social transition has been relatively slow, resulting in tensions between emerging and traditional systems, social norms and mechanisms. These tensions have highlighted a range of social contradictions and led to a decline in social stability (Huntington, 2006). In addition, with the increasingly complex social environment and gradual formation of multiple stakeholder groups, citizens' expectations of the government differ. Traditional administrative models of public affairs management and delivery of public services are no longer meeting the needs of the population, resulting in dissatisfaction with all levels of government. This has led to frequent outbreaks of 'mass incidents' in recent years. Mass incidents, which are defined as demonstrations, picketing, and group petitioning involving more than one hundred people, occur when a disadvantaged group becomes aware of the unequal distribution of limited resources, and consequently is more likely to rebel against those perceived to be the beneficiaries of the system (Yu, 2007).

SCOPE OF MASS INCIDENTS IN CHINA

Our understanding of mass incidents has gone through different stages, with various names allocated, including mass disturbances or "mobs" in the 1950 to the 1970s,

"security incidents" in the early 1980s, "unexpected events", "security incidents", "security emergencies" or "sudden incidents" in the late 1980s and early 1990s; "emergency security incidents" in the late 1990s, and mass public security incidents in the twenty-first century. Various economic, social and political factors have influenced this terminology. Currently, many researchers have suggested that "mass incidents" is the more appropriate term, with such incidents also including minor events like disorderly conduct, unlawful violation, and criminal offenses. Liu (2008) proposed three stages for the recent development of Chinese mass incidents (*quntixing shijian*). During Stage One, in the middle to late 1980s, participants were mainly university students and intellectuals known as "social entity/entity collectives." In Stage Two, from 2000 to 2002, laid-off factory workers and farmers, collectively referred to as the disadvantaged social group (Xu, 2004; Yu, 2007), demonstrated against unreasonable tax policies. In Stage Three, in 2005, participants identified by common land interests, known as the "land right and regional community," protested about their disenfranchisement through forced reclamation of their houses and land. Mass incidents are viewed with considerable concern by the government because of their capacity to mobilize those directly affected by social and economic change, as well as indirect stakeholders, in acts of violence, rioting and civil disobedience. Harmful actions result from many mass incidents, such as vandalism and burning of party committee and government offices and police stations, and some have developed into severe political events as a result of sudden local social tensions within a particular region. These types of spontaneous events are difficult for the government to manage and control.

In 1993, the nationwide number of mass incidents was only 8,700, but this figure increased rapidly during the period 1994–2006 from about ten thousand to more than ninety thousand. The average annual growth rate was around 10 percent between 1995 and 1996, and then rose up to 25.5 percent in 1997–2004 (Chinese Academy of Social Sciences, 2005). During 2004–2006, there were thirty thousand mass incidents with the number of participants growing to 3,760,000 in 2004 from 730,000 in 1994, a fourfold increase averaging 17.8 percent per year. The scale index of national mass incident participants has also gone up from 100 to 515, with figure 26.1 indicating the exponential growth in the number of mass incidents in China (Hu, 2006).

In recent years, there has been an increase in the number of people participating in individual mass incidents, with tens of thousands of people participating now quite common. The spread across industries and regions has also widened, making mass incidents a broad-based phenomenon in Chinese society. While the development of a more pluralistic society in China has led to a social transition process characterised by conflict between rural and urban populations, different regions and diverse social groups, the underlying cause of these conflicts is the inequitable distribution of benefits resulting from economic growth. Mass incidents continue to pose a significant threat to social stability, with "confrontational" politics having the potential to deepen the social crisis and social fragmentation. The key issue for the government is how to manage this situation. The traditional one-dimensional approach by the

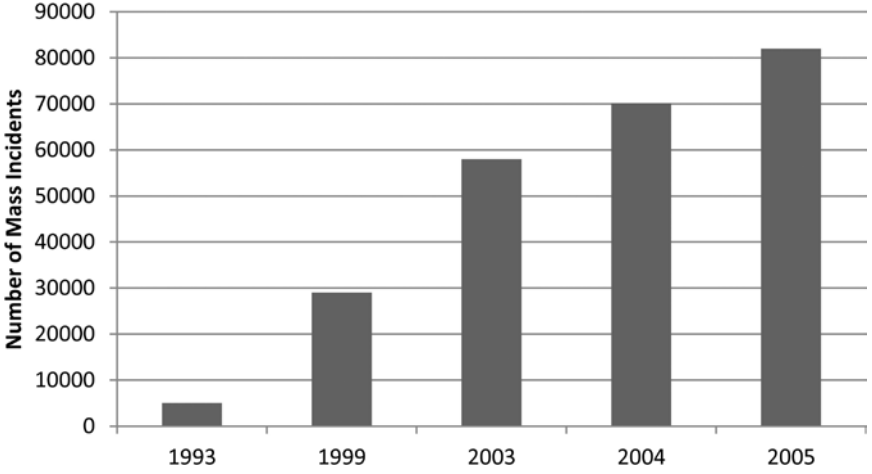

Figure 26.1. Number of Mass Incidents in Recent Years in China.
Resource: Social Blue Print Book, 2005.

government in dealing with such conflicts in the past no longer works in the current social environment. Instead, the government needs to play a greater role in understanding the social-economic requirements of each stakeholder group in society through a multi-layered communication approach, followed by a policy strategy that aims to address inequalities in wages, benefits, housing, and public infrastructure. This is discussed in more detail below.

SOCIAL INEQUALITY, SOCIAL CLASS STRATIFICATION AS THE MAIN CAUSE OF MASS INCIDENTS

A principal cause of mass incidents is the widening income gap between the wealthy and poor, with China now having one of the highest levels of income inequality in Asia (Lum, 2006, p. 10). In a survey of Chinese public perceptions of income distribution, more than 80 percent of respondents felt that China's current income distribution was either "not so equitable" or "very inequitable" (United Nations Development Programme and China Development Research Foundation, 2005). When government services such as education and health care are included, urban residents are six times better off than rural residents (Ma, 2005). The growing income gap and the rise of a new wealthy social class has triggered resentment among the poor, which has contributed to the increase in mass incidents (Chan, 2005).

The modernization and opening up in China through political and economic reform has led to significant changes in social class structure. Chinese society is now much more complex, with many new classes stratified on a range of variables based on wealth, political influence, employment status and geographical location. Weber

(1968) identified a social regime in which class is determined by position, and a political regime, in which class is determined by power. Party and government cadres with identity and authority form the higher classes and are able to secure greater political influence, resources, and benefits. However, the 'proletariat' who lack status and power, can only access resources through their own labour. A person's income and social status determines their class identity and class consciousness, with the latter further determining their social actions. Recognition of one's own class provides the basis of awareness of the level of the conflict between social classes. People who identify themselves as upper class, believe the likelihood of the occurrence of social conflict in the present or future is small, whereas those who believe themselves in the lowest class are more likely to believe there is a much higher probability of the chance of conflict. The latter 'class' are therefore more prone to exhibit extreme levels of behaviour in response to political and economic disadvantage.

Factors that determine people's consciousness of social conflict are different in different stages of social development. When basic needs such as food and clothing for the whole population are not being met and so people are living below the poverty level, poverty becomes the accepted 'social norm' and resentment is unlikely to occur. However, as economic wealth increases and basic food and clothing needs are resolved, class consciousness arises among disadvantaged groups, leading to an awareness of social conflict as a vehicle for change. Thus, class identity becomes an important indicator of people's attitudes and behaviour (Jayadev & Reddy, 2011).

Li and colleagues' (2011) study found that people's subjective recognition of their own class identity shows a "downward drift" tendency in China. Compared to other countries, the number of Chinese people who consider themselves middle class are a minority, with most believing they are in the lower-level classes at the bottom of society. These beliefs influence the nature and origin of conflict. In the eyes of the masses, small fuses that lead to social conflicts are normally disputes between a group representing party staff, government cadres, civil servants and their associates, and a group of ordinary people who are at the bottom of society. When conflicts occur between these two classes, the majority will subconsciously classify themselves in the bottom level. Given the frequent incidents of social conflicts in China, the contradiction between the two social classes is very pointed, and this social class stratification is an important social basis leading to social conflict. In order to manage such incidents the government needs to understand the relationship between class consciousness and social conflict, otherwise mass incidents will continue to flourish.

ROLE OF ADMINISTRATION AND GOVERNANCE MECHANISMS IN MASS INCIDENTS

According to Kriesberg et al. (1989), the process of conflict formation may be divided into distinct but interrelated stages. The conflict exists whenever people have

interests and demand to express these; this is the *latent conflict* stage. The conflict becomes apparent until a "triggering event" appears, this the *emergence* stage of the conflict. This will be followed by either *escalation or settlement or resolution* stage of conflict. In the escalation stage, the conflict can be destructive. The development of mass incidents in China is a dynamic process in which the conflicts emerge, develop and vary according to the way in which the government handles the situation. The brewing and erupting of a mass incident and its outcome reflect the level of latent conflict between the government and various stakeholders, the extent of latent conflict, leading then to the manifestation or escalation of conflict and associated behaviours, which may have serious and usually negative results and impacts on the stakeholders and society. During this process, most mass incidents can be prevented before escalation conflict occurs if the government provides timely and effective responses to negotiate with the masses and find potential settlement methods.

An effective approach to the management of mass incidents is crisis prevention. Crisis prevention relates to the identification of symptoms before a crisis occurs. Crisis management is the mechanism by which governments lead and mobilize the whole society to take effective measures to eliminate hidden dangers arising from a crisis or ensuring that the government is fully prepared before the onset of the crisis in terms of its psychological, organizational, institutional and technical preparations. Once the crisis erupts, the government is then able to launch emergency response plans, to prevent an escalation to large-scale conflict, and to minimize loss. However, in relation to the mass incidents in China, effective primary crisis prevention at the government level is still lacking. This may be an underlying reason for the escalation of small-scale 'street' disputes into large-scale mass incidents.

Having a sense of crisis prevention is the starting point, yet grassroots governments often lack an understanding of the signs that may lead to mass incidents. Some local governments are unaware of local public opinion, disregard public interests, and lack knowledge of mechanisms to prevent conflict, such as negotiation. There are insufficient judicial relief mechanisms for people to access and no effective systems to solve conflict issues. Local government is not aware of the development process from public opinion to resentment and anger, and pays no attention to these public resentments and concerns. Once unexpected events occur, the government is overwhelmed, rushes to mobilize grass roots government police as an interim, emergency response mechanism which often exacerbates the situation due to the lack of organizational and technical preparation.

In summary, the management of mass incidents in China needs profoundly challenging system reform, government ideology and management, and mass incidents will continue to occur if management measures do not adapt to China's rapid social and economic development. The incidents pose a major challenge to district county party committees and governments and law enforcement authorities. Their destructive and adverse social impact on economic and social development is increasing, so it is critical to gain a better understanding of how and when they develop if China is

to maintain social stability and the current pace of its economic and social development.

A CASE STUDY OF MASS INCIDENTS: CHONG QING

Despite increases in mass incidents in China, the causes of the mass incidents and management and government processes have not been investigated. There is no published literature on the prediction of mass incidents using social resentment as an indictor, nor is there research on the role of government administration, public affairs management and public services in relation to the prevention and development of mass incidents from latency through to manifestation.

To address the dearth of research in this area, we undertook a study of mass incidents in Chong Qing, a large city in southwest China. The social and economic circumstances facing Chong Qing provides a unique opportunity to investigate linkages between poverty, social resentment and mass incidents, and to analyse the causes of mass incidents so prevention strategies and mass incidents prevention models can be developed in China. Chong Qing, a city of more than thirty-three million, of which twenty million live in urban areas, exemplifies the increasing resentment among parts of the Chinese population. Some incidents in the city have increased three fold between 2008 and 2009, and in the same period the number of participants increased four fold (Hess, 2011). This has resulted from the unequal distribution of resources, discriminatory local corporate reforms, housing demolition and relocation, government expropriation of rural land, and environmental pollution (Pasarín, Borrell, Brugal, & Díaz-Quijano, 2004). The location of incidents has widened, and now includes cities, rural villages, enterprises, governments and schools. Further, the background of the main participants has broadened to include dismissed workers, farmers, urban dwellers, enterprise owners, teachers and taxi drivers. The displacement of large numbers of people through the construction of the Three Gorges Dam has made the situation even more serious in Chong Qing, as the city had to absorb the consequent unemployed population.

In this study, we used poverty and social resentment at both the individual and area level to measure economic and social deprivation, as these factors may provide early indicators of latent conflict, perceived and felt conflict, which serve as predictors of manifest incidents. Social resentment as an indicator of social deprivation is based on the hypothesis that, in Chong Qing City where a significant proportion of the population are involved in mass incidents, social problems are more likely to exist. We also measured government administration, public affairs management and public services from public servants' perspective to provide insight into the development of mass incidents. In examining the association between income inequality and social resentment in Chong Qing, China we hypothesised that (1) material deprivation, that is, low income, is significantly related to social resentment, and

(2) perceived effectiveness of government administration, public affairs management and public services is significantly related to the high frequency of social incidents.

Methods

A cross-sectional study design was used for the study. Data were collected from October to December 2009 using a mail survey from residents in thirty-eight districts in Chong Qing city, and a mail survey of government officials and public servants. The resident participants were randomly selected from a list of residents aged eighteen years and over, and public servants were randomly selected from a list of those who worked in government from the village level to the municipal level. The sample consisted of five hundred residents, of which 480 returned the survey and of which 465 were usable, representing a response rate of 88 percent. The public servant sample consisted of two thousand people, of which 1,924 were useable, representing a response rate of 96.2 percent. The reason for the high response rates may be because the topic of mass incidents reflected public concerns about the high frequency of incidents. Our study was approved by the Ethics Committee in Research of Human Subjects at Peking University.

In the urban resident sample, the annual average family income was 25,829 Chinese yuan (RMB), and in the rural resident sample, the annual average income was 4,644 RMB, which is below the poverty level in China. In this sample 62.2 percent of the participants had a family income less than 25,829 RMB, representing a significant number of urban poor. In terms of demographic characteristics, 29.6 percent were between eighteen and thirty years of age, and 38.7 percent were between thirty-one and forty years of age. Males constituted 61 percent of the sample, and the majority were working full time (67 percent). The social economic level of the region is officially classified based on GDP, urban resident income level, and rural resident income level, and the region's finance revenue is classified as high, upper middle level, middle and low level (See figure 26.1 and table 26.1).

In comparison with the average SES level in China, Chong Qing is ranked twenty-fourth among thirty-one provinces and municipal cities (table 26.2), and has a GDP level below the average level in China.

Table 26.1. Chong Qing SES level

SES regions	*GDP (Billions)*	*Urban average family income (RMB yuan)*	*Local finance revenue (Billions)*	*Rural family income (RMB yuan)*
High	378.76 (74.3)	32331.50 (2860.50)	17.28 (5.87)	5955 (1091.77)
Upper middle	146.96 (40.7)	23988 (2041.97)	14.62 (2.49)	5223.00 (278.88)
Middle	110.68	22927	4.82	3833.0
Low	51.41 (8.38)	24303 (2362)	4.46 (2.09)	3462.00 (124.01)
Average	**163.26 (133.59)**	**25829 (4272.01)**	**10.74 (6.51)**	**4644.22 (1154.91)**

Table 26.2. Chong Qing SES in comparison with average SES level in China

Ranking	*GDP (billions)*	*GDP Increase rate (%)*	*Population Permanent residents (10,000)*	*Average GDP (yuan) per person*
Cong Qing (ranking 24)	5693.58	11.73%	2816	20219
Average SES level in China	11611.16	8.37%	4197.87	28310

In the sample (see table 26.3), there were 26.5 percent of residents from high SES regions in Chong Qing, about 43 percent of residents from upper middle and middle SES regions, and 30.3 percent of residents from low SES regions.

In the public servants sample (table 26.3), 70 percent were from rural areas. The majority were at the local work unit level, and less than 2 percent were bureau directors and deputy directors (that is, high-level government officials). Twenty-five percent of residents were from high SES regions, about 59 percent of residents were from upper middle and middle SES regions, and the minority (15 percent) of residents were from low SES regions. Most public servants were less than fifty years of age, most of them (60 percent) had diploma-level education, 5 percent of them had primary school and illiterate levels, and only 2.5 percent of them had bachelor and postgraduate degree qualifications. The majority of the public servants (87 percent) worked for units and departments in local government, as shown in Table 26.4.

Table 26.3. Resident participants demographic characteristics

Variables	*N (%)*
Sex	
Male (referent)	281 (61.0%)
Female	180 (39.0%)
Age	
18-30	
31-40	94 (29.1%)
41-50	125 (38.7%)
50 and above	67 (20.7%)
Family income	
3,000 to 26,000	207 (62.2%)
26,001-49,999	157 (34.7%)
50,000 and above	88 (19.5%)
Social Economic Region	
High (n=2)	97 (26.5%)
Upper middle (n=3)	133 (36.3%)
Middle (n=1)	25 (6.8%)
Low (n=3)	111 (30.3%)

Table 26.4. Public servants demographic characteristics

Variables	*N (%)*
Sex	
Male	1226 (64.6%)
Female	671 (35.4%)
Age	
20-30	439 (22.8%)
31-40	779 (40.5%)
41-50	508 (26.4%)
50 and above	197 (10.3%)
Degree	
Illiterate	21 (1.1%)
Primary school graduate	72 (3.8%)
Junior high school	262 (13.7%)
Senior high school	49 (2.6%)
Technical schools	310 (16.3%)
Diploma	1145 (60.1%)
Bachelor and above	40 (2.1%)
Postgraduate degree	7 (0.4%)
Job position	
Clerk	455 (24.1%)
Officer	361 (19.1%)
Deputy Unit director	390 (20.6%)
Unit director	441 (23.3%)
Deputy department director	193 (10.2%)
Department director	39 (2.1%)
Deputy bureau director	4 (0.2%)
Bureau director	6 (0.3%)
Length of working experience	
Less than 5 years	333 (17.4%)
5-9 years	340 (17.7%)
10-19 years	630 (32.8%)
20-30 years	456 (23.8%)
More than 30 years	159 (8.4%)
Social Economic Status in the region	
High SES level	485 (25.0%)
Upper middle level	693 (35.7%)
Middle	464 (23.9%)
Poor	299 (15.4%)
Urban vs rural	
Rural	1340 (70.6%)
Suburban	531 (28.0%)
Urban	27 (1.5%)

Measures

For the residents' sample, the main outcome measure was social resentment, which was based on factor analysis. Social resentment is defined as people's discontent about social inequality and was calculated from seventeen questions clustered into four dimensions of discontent: (1) inefficient government governance and management problems; (2) public affairs problems including difficult transportation, poor environmental health, poor education system and medical service; (3) social insecurity; and (4) anxiety about possible job loss and layoff. Internal consistency analysis using Cronbach's alpha indicates a high level of reliability (0.91) across the four dimensions. The independent variables are income level of residents and the region's SES level. For public servants, the key outcome variables are frequency of general mass incidents and severe mass incidents. The independent variables are the region's SES level, areas of mass incidents, causes of mass incidents in relation to management and governance, barriers in management and governance processing of mass incidents, and capabilities of public servants in dealing with mass incidents.

Results

The distribution of people's perception on each social resentment question is published elsewhere (Sun, Buys, & Wang, 2012). These results indicate a high degree of social resentment with over 50 percent of participants (bolded) agreeing that there was poor government management, inadequate public affairs and poor social security arrangement. They also had worries about job layoff due to economic reform and the restructuring of enterprises.

The social resentment of residents was further analysed by comparing the difference among different SES regions. Table 26.5 shows that SES status is related to social resentment. In particular, with increasing levels of SES in the region, there is a progressively increasing level of social resentment and complaints about social welfare and social security. Further, there is a progressive increasing level of complaints related to job loss and employment. In government governance and management, there are higher levels of social resentment in high SES regions than in upper middle SES regions. In public affairs, including education and environmental pollution issues, there is a higher level of social resentment from high SES regions and low SES regions than from upper middle SES regions.

In summary, there were high levels of social resentment, which are significantly related to social economic levels of the regions. In the following analyses, the occurrence of mass incidents and severe levels of mass incidents were analysed using logistic regression to examine the relationship between occurrence of mass incidents and its causes in relation to government management and governance mechanisms.

Findings indicate, as demonstrated in table 26.6, that the causes of the everyday occurrence of mass incidents and severe mass incidents are mainly related to relocation issues and accidents, business owner's rights and social injustice. In addition, frequently occurring mass incidents are also related to welfare problems, government

Table 26.5. Differences between different SES regions in social resentment

Variables	*High SES (N=85) A*	*Upper Middle (n=121) B*	*Middle SES (n=24) C*	*Low SES (n=111) D*	*F*	*Post hoc*
Governance	4.65 (0.51)	4.63 (0.28)	3.84 (0.70)	4.27 (0.02)	4.76**	A>B**
Public affairs, education, environment pollution	4.32 (0.86)	3.96 (0.94)	4.07 (0.82)	3.76 (0.69)	43.88***	A>B*** B<C*** B<D***
Social welfare, social security	4.37 (0.00)	4.86 (0.00)	4.76 (0.00)	4.43 (0.00)	39.23***	D>B*** C>B*** B>A* C>A*** D>A***
Job loss and employment	4.46 (0.39)	4.84 (0.42)	4.67 (0.18)	3.94 (0.28)	31.60***	A>B*** C>B*** D>B*** C>D***

*p < 0.05; **P < 0.01; ***P < 0.001

Table 26.6. Causes of occurrence of general mass incidents and severe mass incidents

Variables	*N (%)*	*General incidents*	*Severe mass incidents*
Causes of MI			
House relocation	1721 (88.8)	1.73 (1.28-2.33)***	2.25 (1.59-3.19)***
Accidents	921 (47.5)	1.41 (1.16-1.71)***	1.41 (1.17-1.72)***
Employer and employee	976 (50.4)	1.31 (1.08-1.60)	1.50 (1.22-1.83)***
Environment pollution	462 (23.8)	1.15 (0.91-1.46)	0.61 (0.48-0.87)***
Lawful conflict	719 (37.1)	0.87 (0.71-1.07)	1.14 (0.92-1.40)
Welfare problems	714 (36.8)	1.44 (1.18-1.77)***	0.87 (0.71-1.07)
Lands rights	559 (28.8	1.86 (1.48-2.33)***	1.25 (1.00-1.57)*
Transport management	434 (22.4)	1.31 (1.02-1.68)*	1.26 (0.99-1.50)
Social injustice	362 (18.7)	1.33 (1.01-1.75)*	1.41 (1.09-1.84)**
Unreasonable system	290 (15.0)	1.00 (0.76-1.32)	1.10 (0.83-1.45)
Corruption	285 (14.7)	0.74 (0.56-0.99)*	1.20 (0.90-1.59)
Family conflicts	190 (9.8)	0.46 (0.33-0.64)***	1.19 (0.86-1.65)

*p < 0.05; **P < 0.01; ***P < 0.001

Table 26.7. Government management and governance as causes of mass incidents

Variables	*N (%)*	*General incidents*	*Severe mass incidents*
Slow government response	659 (34.1)	0.97 (0.79-1.20)	1.15 (0.93-1.43)
Uncoordinated actions	1148 (59.3)	1.22 (1.00-1.49)*	1.06 (0.87-1.30)
Unreasonable plan	631 (32.6)	0.97 (0.78-1.20)	1.44 (1.16-1.79)***
Media speculations	1141 (59.0)	1.36 (1.10-1.67)**	1.49 (1.20-1.85)***
Unreasonable demand mass	1095 (56.6)	1.22 (0.99-1.51)	1.34 (1.08-1.66)
Early warning system incomplete	763 (39.5)	1.06 (0.86-1.29)	1.14 (0.91-1.37)
Do not understand the mentality of masses	973 (50.3)	0.75 (0.62-0.91)**	0.82 (0.67-0.99)*
Barrier to information	742 (38.4)	1.29 (1.06-1.58)**	0.81 (0.66-0.99)*
Unsmooth communication	564 (29.2)	1.46 (1.18-1.81)***	0.84 (0.67-1.04)
Insufficient personnel	1063 (55.0)	1.25 (1.03-1.51)*	0.99 (0.82-1.21)
Masses do not trust policy	1169 (60.5)	1.27 (1.03-1.56)*	1.39 (1.12-1.72)**
Trouble people magnify the event	844 (43.7)	1.18 (0.96-1.44)	1.17 (0.95-1.43)
Public servant's incapability	768 (39.7)	0.86 (0.69-1.06)	1.45 (1.17-1.79)***

*p < 0.05; **P < 0.01; ***P < 0.001

Table 26.8. Occurrence of mass incidents in different SES regions

Variables	*High SES*	*Upper middle*	*Middle*	*Low*	*Chi square*
Daily MI	238 (49.6%)	267 (38.6%)	157 (33.9%)	117 (39.5)	25.96***
Severe MI	238 (49.6%)	267 (38.6%)	157 (33.9%)	135 (45.2%)	35.21***

corruption and conflicts among family members. Severe mass incidents are also related to conflict between employers and employees and environmental pollution.

Table 26.7 provides findings related to management and government mechanisms for dealing with mass incidents. These results show that the occurrence of mass incidents is mostly related to government's uncoordinated actions among departments, the media's magnification of events, mass mentality which is misunderstood by public servants, barrier to information and the absence of smooth communication between the public and governments. Furthermore, there were insufficient government officers to deal with the mass incidents, and the population did not trust government policy.

For mass incidents that were out of control, the main causes related to government management including unreasonable government management plans, media speculation, mass mentality which cannot be understood by the government, barrier to information, government policy which did not consider the public's interests, and public servants' lack of capability to deal with mass incidents.

The prevalence of daily occurrence mass incidents and severe mass incidents in different SES regions shows that there were more mass incidents occurring on a daily and frequently occurring basis in high SES regions than in middle and low SES regions (see table 26.8). This finding suggests that the occurrence of mass incidents are significantly related to the region's rapid social economic development and its companying widened gap between the rich and poor.

CONCLUSION

Social resentment is closely related to relative poverty. Those people living in the low SES regions have higher levels of social resentment than those living in high SES regions, with resentment related to issues such disparities in the distribution of social welfare, experience of job loss and lack of available employment. Both the public and public servants indicate that the main reasons for the occurrence of daily mass incidents and for disputes evolving into large-scale mass incidents are inequalities in resource distribution in areas such as compensation for the cost of relocation, protection of business owners' interests and rights, and compensation due to accidents.

Although the Communist Party and central government have strengthened the concept of building a harmonious society (Communiqué of the Sixth Plenum of the 16th CPC Central Committee, 2006), the imperative for local government leaders to achieve economic results often sets up incompatibilities between the competing

aims of social progress and economic outcomes. Government authorities and corporate capital form alliances that lead to corruption and decision-making processes that ignore the interests of some constituents. In effect, government operatives restrict information and control decision making in an attempt to achieve quick results. In practice, this approach leads to an inequitable distribution of benefits. The resultant problems are often compounded by governments' use of a single, forceful, top-down approach, which engenders high levels of hostility and dissatisfaction. Before making decisions, local governments need to take the time to scrutinize the benefit-demands of all stakeholders and optimize the distribution of benefits to each stakeholder group. The consequences of not doing so can be seen in Chong Qing—an increase in government dissatisfaction, which when ignored triggers incidents whereby the public assemble to seek solutions to their grievances and answers from the government.

Social Inequality Is the Main Cause of Mass Incidents

Although party and government cadres maintain that reforms have led to a high degree of social equity, the majority of poor people have a strong sense that they have been disadvantaged by these changes and society is less fair. This has provoked a strong sense of resentment as demonstrated in Chong Qing, where more than 50 percent of the public were not satisfied with government governance, public affairs, social welfare systems, and were worried about employment and job layoffs, all factors which increase the likelihood of social conflict. For example, the large number of laid-off workers has not only drastically reduced incomes and increased the number of people living in poverty compared with other social sectors, but also has decreased economic status, where now more than 62 percent of the public have an annual income less than 20,000 yuan. Increased levels of psychological stress and perceived grievances lead to emotional intensification and confrontation, which are important precursors of social conflict.

The concept of social equality has an important role to play in understanding and ameliorating mass incidents. Social justice refers to a situation in which the interests of all sectors of society are well coordinated, contradictions among the people and other social contradictions are dealt with properly and social equity is implemented and effectively maintained (Xu, 2004). The pursuit of social justice as a key government policy is viewed as a characteristic of a humane and democratic society. In a market economy, social justice can be understood in terms of three principles of equality. First, the equal opportunity principle emphasises that people have an equal chance to acquire resources during the social wealth creation process. This is a precondition for equality. Second, the interest distribution principle emphasises equal wealth distribution according to the contribution of each stakeholder. In this way equality during wealth creation is created. Third, the compensation principle emphasises the assistance and help provided to disadvantaged groups during the competition and interest distribution process, so they have basic social security. This is known as compensation equality (Xu, 2004; Yu, 2007).

Prior to 1978, when China opened its door to western countries and reform, it experienced high levels of equality. However, this phenomenon was an absolute egalitarian "iron rice bowl" type of equality. It was obtained at the expense of economic efficiency and productivity. In recent reforms in the area of income distribution, the government proposed dual aims of efficiency and fairness in its policies. The idea behind such reforms is to recognize social disparities but achieve progress by encouraging some people and regions to accumulate wealth through honest labour, and then improve the overall welfare of society by way of compensation. While these ideas have promoted rapid social and economic development in China, the level of compensation to those on the margins of society has been inadequate, expanding the extent of social inequality. Consequently, social justice issues are increasingly becoming a major social problem in Chinese society today.

From the above discussion, the conclusion can be drawn that a sense of social equality and social conflict are closely related. If people believe that their society promotes a high level of social equality, the possibility of social conflict is relatively low; on the other hand, if they perceive that they have been unfairly treated by others in an unjust society, then the likelihood of social conflict is high. As Dahrendorf points out (1958), differences in interests between groups, such as disparities in wealth and political status, become mutually superimposed and conflict between groups will become more intense. Conversely, groups of similar economic and political levels will have less conflict. In summary, a sense of social inequality is a primary cause of social conflict, and is the main reason why disaffected members of society turn from spectators into active participants in the process of social conflict.

Ineffective Management

Findings of our study indicate that ineffective management in the local government are the main causes of escalating general disputes into mass incidents (see table 26.7). These include unreasonable management plans, the media's speculations, barrier to information and communication between the government and masses, and an inability of public servants to manage the incidents and understand the mentality of masses.

With the prospect of rapid change in this area, local governments need to adopt strategies to manage such conflicts when they occur. However, there are a number of reasons why local authorities lack the capacity to implement effective strategies in this area.

Although party committees and governments generally have information systems which report early conflict warnings and emergency response mechanisms, they are often unable to provide timely and effective responses so that situations deteriorate. While large-scale mass conflicts usually arise from relatively small incidents, governments cannot respond with coordinated plans and actions to prevent their escalation into severe mass conflicts. This shows that local governments' crisis management

approach, particularly at a grass roots government level, is characterized by a lack of prevention, early warning and pre-control mechanisms.

During the process of dealing with disputes, government cadres tend to use simple measures and ignore the "spread effect" of mass incidents. They often take the attitude of 'act on the matter on a case basis'. They often lack compassion towards the people who are in the disadvantaged situation, and are reluctant to respond in an organized fashion when provided with information relevant to disputes. Rather than dealing with rumours, responding to and solving problems in a timely manner and finding solutions for disputes, governments tend to ignore these situations. People then believe rumors and respond on an emotional level, which can intensify the situation. For example, in one incident in the Wanzhou District in Chong Qing, police did not explain the situation to the public and instead gave onlookers a sense that they were covering up for "officials". The authorities' failure to promptly correct this led to accumulated discontent and hence large-scale conflict.

'Benefit expression' refers to people in different socio-economic classes overtly expressing their demands to government, party and organisations at different levels via certain channels to influence the political system and the output of public policy. This occurs through a system of petitioning the government. In most mass incidents of recent years, lack of local government communication usually became the trigger for the incidents. For example, in one incident petitioners to the government (Cheng, 2005) had to wait eight hours to meet with an official, illustrating the ineffectiveness and delays inherent in the petitioning system. Further, the absence of "advocates" to assist in resolving issues also contributes to the exacerbation of minor matters into mass incidents.

In order to prevent mass incidents people need a benefits expression system that responds to stakeholders' interests. In a pluralistic, democratic society there is always a balance between different stakeholders, with opportunities for the public to communicate their needs and political aspirations through various channels and forms of direct participation. A harmonious society is not necessarily characterised by the absence of conflict, but it is one that has an ability to resolve conflicts of interest through political, social and judicial mechanisms.

At present, China's economic interests and social development problems reflect considerable communication defects in relation to mechanisms for expression to governments, particularly for vulnerable groups. These groups currently have little recourse to resolve their social problems, often compounding their level of disadvantage. Their lack of opportunity to create and accumulate wealth in society, compete for jobs, and lack of social rights are all recognized as important features of this disadvantage (Xu, 2004; Yu, 2007). The lack of effective channels to express their interests and demands, and in the process of the formation of public policy, means that they are often marginalized. When these groups are unable to express their interests and demands through normal channels, they may resort to civil disobedience, such as violence or rioting, thereby intensifying the conflicts and affecting social stability.

The interests of vulnerable groups are therefore an important issue of social stability and cannot be ignored by governments.

Mass incidents could be better identified before the outbreak of crisis. Warning measures could be developed through effective information gathering, transmission, processing and dissemination. The rationale for the establishment of early warning mechanisms is to provide information in a timely manner to make accurate judgments about the outbreak of the crisis and to ensure the timely release of information to prevent escalation. In China the development of early warning systems remains difficult and challenging, and therefore public health prevention and management of incidents continues to be impeded. The absence of such mechanisms is a major source of social conflict. Although many regions are now establishing crisis early warning systems, they have not developed the scientific forecasting and decision-making advisory networks needed to optimize the effectiveness of these systems. In particular, there is no established national and local integrated information system that enables interactive communication and information exchange, thereby greatly reducing the sensitivity and efficiency of crisis warning systems. There is also a lack of a comprehensive information gathering, management and release system.

Our findings from public servants indicate that the public does not trust government policy and felt it did not reflect their interests. This was viewed as a primary cause of mass incidents. The public has little faith in formal channels of communication and the one-dimensional government information transmission system. There is a need for a multi-dimensional communication approach where accurate descriptions of incidents can be provided and resolutions quickly implemented. As the Internet and mobile communication industry rapidly develops, information can be delivered on a large scale in a very short time. There is also mistrust between individuals, groups and organizations, which results in further marginalization of vulnerable groups. Crises in trust lead to suspicion and hostility, and the perception of a state and society in disorder. The consequent weakening of government legitimacy foments a sense of instability and insecurity among the population.

Research Implications

The current study provides an understanding of the dual nature of mass incidents, in which they have a negative effect in not being conducive to social stability and social development, but at the same time can promote positive social integration and coherence if they are appropriately managed. In China, a large number of mass incidents occurred in front of party and government buildings, involving road blockages, destruction of office facilities, and anti-government graffiti. Governments hold extremely negative views of mass incidents because they breach social norms, disrupt social order, and are antithetical to social stability.

Despite the social disruption arising from mass incidents, there are positive aspects to such incidents related to social development. They can provide a release for long-term accumulated resentment and also provide a warning to governments that social

problems, conflict and tensions, if left unattended, will undermine the legitimacy of the State. As a consequence governments are compelled at all levels to accelerate democratic reforms. American sociologist Lewis Coser (2003), for example, claimed that through mass incidents society can adjust to the challenges of social and environmental changes. A flexible society will benefit from conflict behavior, because conflict behavior improves and creates new norms to ensure the society remains resilient and is maintained under the changed conditions. In regard to the current mass incidents in China, the vast majority of incidents are generated among the people, as a result of the intensification of existing contradictions. The intention is not to overthrow state power and the existing social system. The target is not generally the national government or party but is more a reaction against social inequality issues.

The research implications of this study are an understanding of social inequality, management systems and their role in preventing, monitoring and handling mass incidents, through (1) establishment of a social equality system so that the interests of all sectors of society are well maintained, contradictions among the people, the organizations and sectors are dealt with properly and social equality is implemented and effectively maintained; (2) developing effective pre-mass-incident warning mechanisms to provide information in a timely manner to make accurate judgments about the outbreak of the crisis and to ensure the timely release of information to prevent escalation. Scientific forecasting and decision-making advisory networks, and sensitivity and efficiency of crisis intervention systems, are needed to optimize the effectiveness of prevention and management of incidents.

Social Implications

The results of this study have a number of implications in terms of potential social responses to mass incidents. Regarding the rights and interests of the people, the most effective response is to create a safeguard mechanism to allow people's self-expression. Communication channels are needed for people facing social disadvantage so they can express and seek resolution of their grievances before they escalate into mass incidents (Tsinghua Social Development Team, 2010; Yu, 2007). The people's courts, the people's congresses and their standing committees at each level have the duty and responsibility to receive complaints, suggestions and criticisms from citizens. However, there is no one agency with a clear stipulation to coordinate a response to mass incidents. It is important to set up a specific department within government to manage mass incidents in an integrated and coordinated manner using a whole-government approach.

At present the public have limited channels to represent their concerns. The most authoritative representative body in China is the people's congress, but due to limitations of time and the quality of people's deputies, this channel cannot fully reflect the aspirations of the people. The public receives information through various bureaucratic channels, but this access is convoluted, so messages to and from the government are distorted, affecting the validity and timeliness of communication.

Mechanisms are needed for conveying government information and strengthening communication with the public. Mass incidents are not sudden and unpredictable, but they are usually a long-term accumulation of mass discontent. Approaches involving communication and mediation can prevent incidents evolving from latent into manifest behavioural conflicts. Specifically, local governments should publish official information regularly through a variety of media, implement more transparent administrative structures which are subject to public scrutiny, and hold public forums to gauge public opinions on various issues.

Public hearings, democracy symposia, dialogues between government leaders, or any other kind of idea exchanges are all positive communication channels. This communication access should be merged into an institutional communication model, providing the public with a multi-dimensional platform to express their demands. Through this platform the government can understand the interests of all stakeholders and achieve coordination and integration of social interests during the process of policy formulation and implementation. Furthermore, it can actively foster and build communities and organizations, using their networks as an intermediary and information exchange centre between the government and the people. This will enable socially vulnerable groups to express grievances, which can promote conflict mitigation. The petition system also needs improvement to make clear the responsibilities of upper and lower governments in petitioning and to encourage local governments to regularly meet with representatives of petitioners.

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27

Housing and Identity in Postcolonial Portugal

Derek Pardue

> *The city lives and is transformed with aims and projects, but also with strict but liberal management of its heritage.*
>
> (Salgado and Lourenço, 2006, p. 10)[1]

> *All identities, whether personal, collective, national, racial, religious, are the results of an accumulation of cross-fertilization of identifications and differentiations that are, a posteriori, reified overall as a series of cultural items, e.g., names, places, times, objects, persons documents, etc.*
>
> (Pina-Cabral, 2002, p. 215)

One of the greatest challenges of city management is to align the structures of development—urbanization, and the experience of personal or social development—that is, urbanism. Similarly, for anthropologists and social scientists, the city poses the following theoretical question: what is the role of space in the creation and maintenance of social relationships and structures of stratification? Certainly, this has been a topic of scholarship and public policy, as a number of geographers, historians, sociologists, and anthropologists have contributed insightful analyses into the shifting significance of the neighborhood during different political-economic regimes.[2] In addition, a significant cadre of interdisciplinary scholars has investigated the relationships between migration and identity in the dynamics of city spaces.[3] I write this chapter also in dialogue with those in post-colonial studies, who since the early 1990s have critically pondered whether or not the "post" in post-coloniality signifies any rupture in power or epistemology (Pratt, 1992; Frankenberg and Mani, 1993). My specific intervention is to trace the factors of language and ethnicity in the meaning of certain neighborhoods as Lisbon, Portugal, transitions from colonial metropole to a multicultural member of the European Union.

Space has always been central to human notions of value and power. With the emergence of the Euro-centric notion of modernity and complementary formations of industry and real estate, the city became a focus of identification through labor dynamics and a harbor of collective memory through institutions of patrimony. Referring to the quote above from Portuguese geographers, Salgado and Lourenço, one might ask of the postcolonial city: can signs of migration count as heritage? Likewise, Portuguese anthropologist Pina-Cabral provokes one to consider the processes by which identities are reified as places, that is, neighborhoods. In this chapter I discuss the entangled processes of occupation and urban planning in "postcolonial" Lisbon, Portugal, referring to the current period after the decolonization wars and independence struggles of the 1960s and 1970s in former Portuguese colonies in Africa. The term "occupation" refers to a more agentic process of migrants establishing and maintaining residence in the former metropole of Lisbon. Given the circumstances, this process has often resulted in improvised neighborhoods located in undesirable plots of land on the periphery of the city center. The latter term of "urban planning" refers to systematic state projects intended to provide infrastructure and manage such demographic phenomena.

In post-WWII Portugal migrants from the countryside met significant groups of Cape Verdeans and to a lesser extent Angolans and Mozambicans to remake the areas of Loures, Seixal, Barreiros and Amadora into large, suburban residential locales of Lisbon. By the mid-1970s and the demise of the Salazarist regime, signaled by the Carnation Revolution (Revolução dos Cravos), more "Luso-Africans" along with the so-called returnees (retornados), thousands of former officials, laborers and their families under the Portuguese colonial regime abroad in the PALOP (African Countries with Portuguese as the Official Language), moved into these same Lisbon suburbs.

Over the past fifteen years, the Lisbon landscape for the underemployed, working classes has gradually changed from a mixture of the "social" and auto-constructed to almost exclusively "social"—planned and standardized according to a template of clustered apartment buildings around a central plaza with accessible streets of commerce providing basic services of groceries, baked goods, café, popular restaurants, clothing, hardware and household items. What does this transition mean to residents and to agencies of the state? While agencies of urban planning publish reports and create an archive of modernization projects, everyday dwellers' voices are inconsistently registered. To this end, I draw from ethnographic data from my fieldwork with local youth, especially rappers, who are Cape Verdean or descendants of the archipelago nation-state. I argue that "creole" rappers' life stories give insight into the meaning of place and the politics of post-coloniality in urban Portugal by emphasizing the spatial qualities of the Kriolu language in everyday life and the shortcomings of the state's urban renewal projects involving massive relocation of migrant communities. Kriolu is a hybrid idiom of Portuguese and West African languages that has been spoken for over five hundred years and constitutes the national but unofficial

language of Cape Verdeans at "home" on the archipelago off the coast of Senegal and abroad in the extensive diaspora.

The focus of this article is not on rap music but rather on the rapper as a particular kind of social agent, whose life investment, the act of speaking (rap), often articulates conditions of not only political and aesthetic import but also spatial significance. Rappers are adamant about speaking and, more to the point, forceful in bringing awareness to how they speak. In the case of young, underemployed rappers, who are marked as immigrants, dangerous, and African, the manner of rhymed speech (and, in this case, the linguistic code of Kriolu) reflects the challenging realities of post-colonial conditions in Europe. After an interpretation of modern urbanization and immigration in Lisbon, I provide a qualitative analysis of the dynamic relationship between housing and identity through two ethnographic case studies of neighborhoods in Amadora, an adjacent municipality to Lisbon proper and a central area of migration since the 1950s.

LISBON SPATIALITY: A HISTORICAL PERSPECTIVE ON MIGRATION AND IDENTITY

Lisbon has always been the center of Portugal, and during periods of early modernity, a center of Iberia and Europe more generally. Similar to most cities, its gradual expansion outside of the fortress and trading post boundaries represented the so-called modern dynamics of labor and demographics. During the sixteenth, seventeenth, and eighteenth centuries such expansion produced neighborhoods such as Alfama, Bairro Alto, and Martim Moniz, which by the late twentieth century had become landmarks of fado music, night life, and multicultural marketplaces, and thus part of Lisboeta, and by extension Portuguese, cultural patrimony. Such folk geographies combined with the modernist planning of radial avenues and the public squares of the Baixa district, coordinated by the Count Marquês de Pombal after the horrific earthquake of 1755, formed the pre-industrial Lisbon.

After the 1881 "Industrial Survey" (Inquerito Industrial), a state evaluative report on national industries and their relative organization, city administrations in Lisbon, Oporto and Setúbal, the Portuguese centers of production, began to consider more seriously the geography of labor and responded in two ways: "pátios" and "vilas." The former refers to annexes and ad hoc construction for laborers behind the houses of elite urban property owners. A similar process occurred in buildings of extinct religious orders, convents, and dilapidated palaces, all of which became rental property. Over the last three decades of the nineteenth century, the emergent market niche of real estate developers strove to standardize the "patio" phenomenon and codified it as the "vila." In 1902, official reports estimated the number of vilas at 130 in approximately twenty districts of Lisbon featuring different architectural types, such as the "correnteza," the shape of a tributary stream, directly attached to an industrial factory complex.

The beginning of "bairros sociais" ("social neighborhoods") with the construction of Ajuda and Arco do Cego dates to 1918. The idea was to differentiate the "social neighborhood" from the "vilas operárias" by giving greater attention to façade detail; however, there were several delays and, in the end, these residences were not accessible to working classes but were sold to middle classes. The modernist project of "dar direito de cidade" ("extend city rights," phrase in a manner comparable to citizenship) misfired, as it would many more times throughout the twentieth century (Pereira, 1994; Tostões, 2006).

The maps (figures 27.1 and 27.2) demonstrate graphically a couple of demographic points.[4] First, the "bubble" map shows that the great majority of migrants has held Lisbon as the primary destination with Porto in the north and the Algarve, a tourist region in the south, as secondary areas. The map pair directly above provides information concerning the transition away from "classic" types of housing to more "social" and improvised housing since 1981. This also includes contemporary residential projects of "gated communities" as part of the "peripheralization" of urban Portugal. Again, the metropolitan areas of Lisbon and Porto are where this transformation has been most intense.

Since the 1950s there has been a steady increase of domestic migration into the Lisbon metro area. According to Baptista and Moniz (1985), between 40 and 60 percent of Lisbon was inhabited by non-natives in 1981, with some sections of the city with as high as 75 percent. Until the 1960s most newcomers to Lisbon hailed from the north and interior of the small country. The greatest pull factor was and continues to be labor in the form of large state public works projects of post WWII as well as multinational corporate investments, particularly after Portugal's entry into the European Union in 1986.

According to Ferreira (1987), the initial attitude of the Salazar regime (1932–1968) towards housing was more rhetorical than pragmatic. Housing served a role in family "social formation" as part of larger statist statue of "social provision." This lack of attention by the State resulted in a gradual development of improvised neighborhoods, or what are termed "tin can" (bairro de lata), "clandestine," "tent phenomena" (fenómeno barraca), and "dilapidated" neighborhoods (bairro degradado).

In the 1950s the fascist state under Salazar began to address housing through a reinvestment in "social" neighborhoods to combat the surge of "bairros clandestinos" outside of the municipality proper (Cardoso and Perista, 1994). Pereira remarks on the similarity in look and function between the clandestine neighborhoods and the earlier working-class vilas, the difference being that starting in the 1950s the laws around residential property had changed, contributing to a stigma levied against those in the "clandestine," auto-constructed communities.

In the case of Lisbon, demographic and economic shifts during the latter decades of the Salazar/Caetano regime (1932–1974) transformed the districts and municipalities in the so-called North Margin (margem norte) and South Margin (margem sul), which previously had been riverside weekend getaways for the Lisbon elite or countryside estates (quintas), into locations of factories, transportation hubs, and

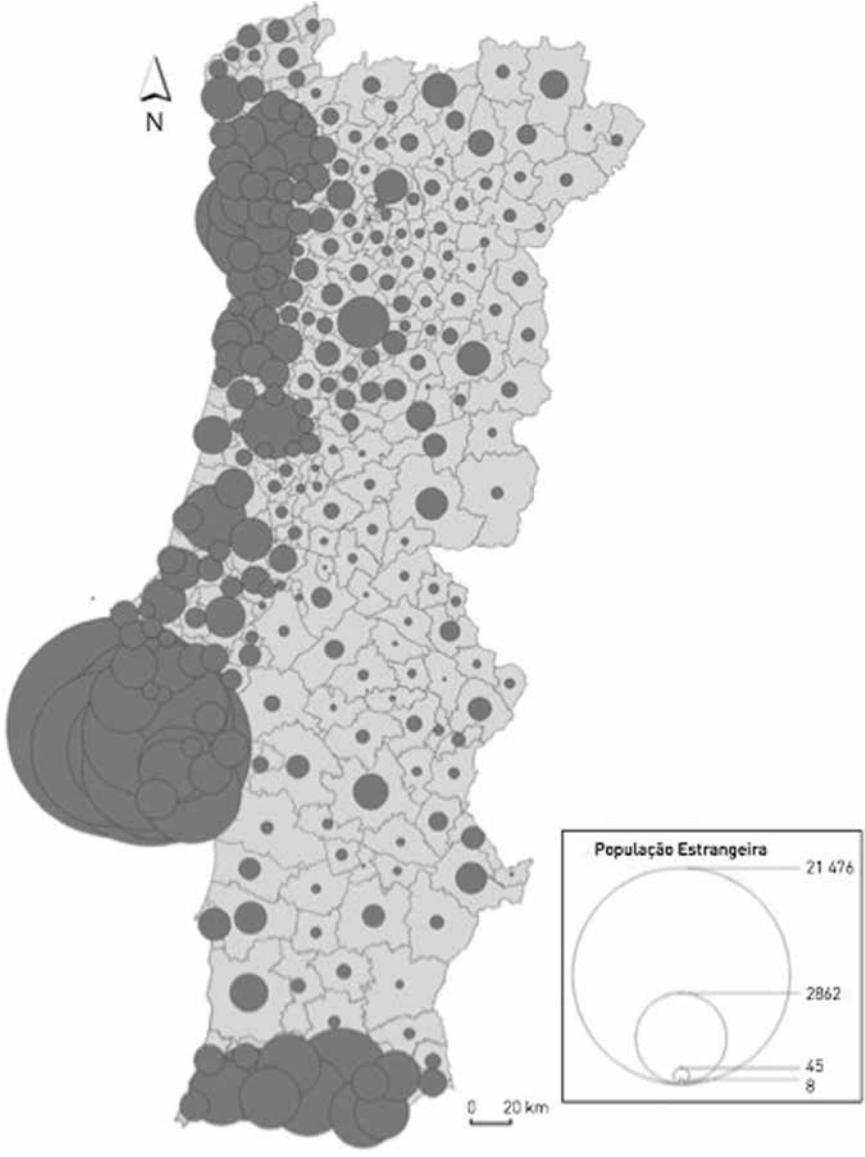

Figure 27.1.

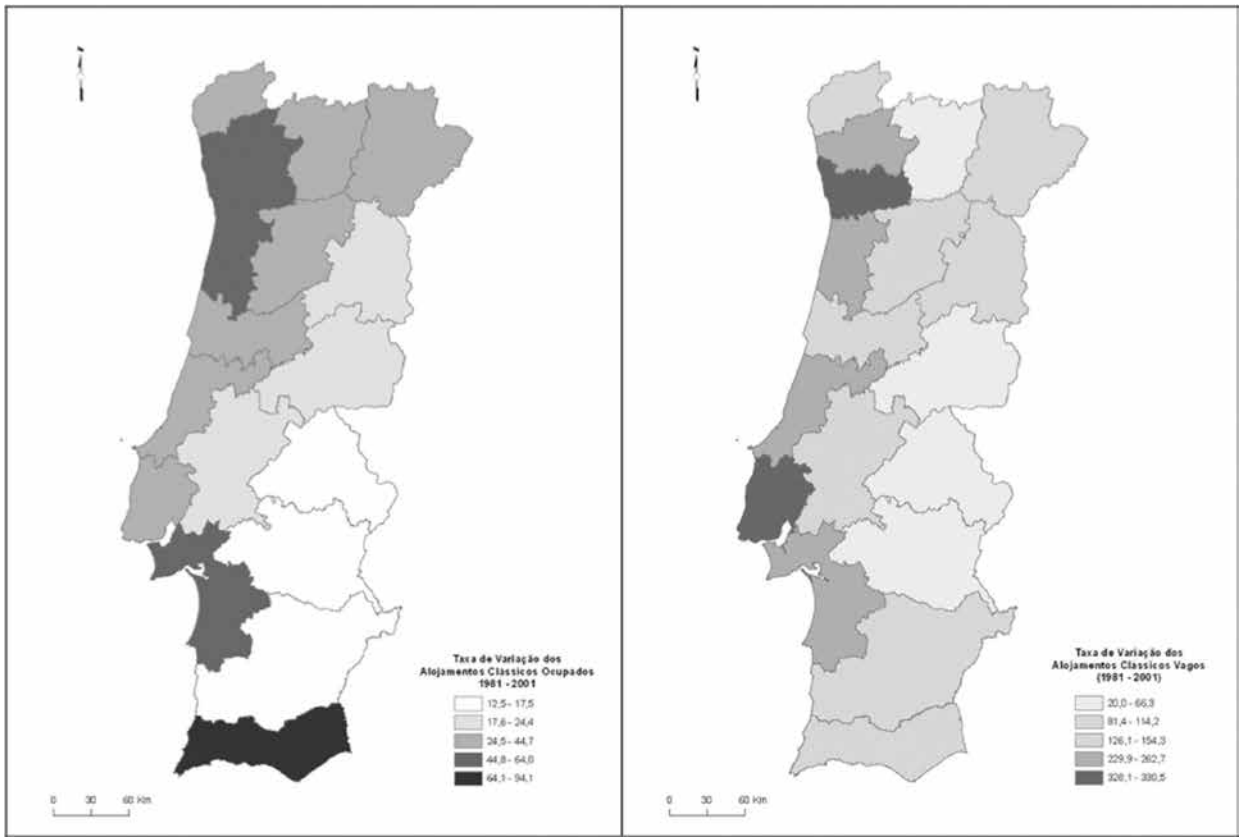
Taxa de Variação dos Alojamentos Clássicos Ocupados 1981 - 2001
12,5 - 17,5
17,6 - 24,4
24,5 - 44,7
44,8 - 64,0
64,1 - 94,1
0 30 60 Km
Taxa de Variação dos Alojamentos Clássicos Vagos (1981 - 2001)
20,0 - 66,3
81,4 - 114,2
126,1 - 154,3
229,9 - 262,7
328,1 - 330,5
0 30 60 Km

Figure 27.2.

intermediary market places. From an architectural perspective, the period of the 1950s and 1960s represented a departure from the tree-lined entryways and organized common space of state housing projects such as the neighborhood Alvalade. The emergent municipalities of Amadora and Benfica consist of large clusters of "free composition of blocks and towers," according to architect and scholar Nuno Portas. In this context, "free" implies less organized through an ad hoc process of demographic coping. Ana Tostões describes this urbanization change as "programmatic" in that it "created a new situation within the framework of officially promoted social quarters (bairro social), which were traditionally composed of detached houses with a courtyard that projects a rural image of the 'village' (vila) crossed with the influence of the garden city" (Tostões, 2006, p. 26).

Cardoso and Perista offer a more nuanced analysis of proletariat housing. For them, the state project of relocation reveals a socio-geographical delineation along the lines of architectural style and ethnicity. Based on an interpretation of scholarly and demographic studies regarding residence and poverty in the 1980s and early 1990s, Cardoso and Perista conclude that "nationals" frequently lived in "classic dwellings," meaning relatively more standardized residences with conventionally divided rooms located near downtown Lisbon. These residences, while "run down," did not demonstrate overcrowding, with the majority of units consisting of fewer than five persons. Meanwhile, "immigrants," especially those from former African colonies or PALOP, lived in "spontaneous," overcrowded, poorly divided habitats in the peripheral areas outside of Lisbon proper (Cardoso and Perista, 1994, p. 104).

The element of ethnicity made manifest in racialized phenotype—black Africans—and language—Cape Verdean Kriolu—distinguishes the case study of Lisbon urbanization and attributed social value. The tensions around development and value are not relegated to solely urban planners and politicians. I offer the following interpretations of local fieldwork as an attempt to track the subtleties of value, stigma, occupation and ultimately agency in the prospect of articulating identity to space.

RAPPERS' PERSPECTIVES ON NEIGHBORHOOD IDENTITY

The remaining portion of this chapter focuses on the spatialization of marginalized identities and the concurrent tensions around inclusion and belonging. I discuss this through two neighborhoods, Cova da Moura and Casal da Boba, which provide instructive data on the relationships between language, space, identity and urban policy. While Cova da Moura is (in)famous as Lisbon's largest improvised neighborhood of almost exclusively residents of Cape Verdean descent, Boba is a much smaller and much more recent state project of the "social neighborhood." Both neighborhoods are occupied by folks of Cape Verdean descent and are landmarks in the Lisbon rap scene. More specifically, they are part of what is called the rap from the Linha Sintra,

the train line that connects Lisbon to the mountainside hamlet filled with castles and estates of former nobility. In contemporary Lisbon, the Sintra Line is a corridor of working-class communities with high concentrations of immigrant families.

The Portuguese state in conjunction with real estate developers and European Union funding agencies maintain a goal of regulated urbanization and are well on their way to eradicating improvised neighborhoods. As documented in films, personal testimonies and government reports, the process of demolition is slow. Transition takes places over the course of years and is an arduous experience. Interestingly, many of the most well-known and respected Kriolu rappers have emerged from the milieu of a multi-layered transition—from Cape Verde to Lisbon and from improvised to social neighborhoods. This is the case of Ghoya, a Kriolu rapper, who along with his rapping partner, Boss, demonstrate the problems of current relocation projects and the significance of Kriolu as a coping mechanism that they hope to popularize and impose as a neighborhood signature.

BOBA

> I began to visit the friends I had made in Fontaínhas [improvised neighborhood in Amadora] in their new white homes [in Boba]. We were all perplexed in the face of the ghostly décor, without life, without cafés, without commerce. Nothing. It was in this ambience that the film began, with eyes fixed on the white walls that belong to the residents because they didn't build them (Costa in Faria, 2006).

Pedro Costa, the acclaimed Portuguese filmmaker, produced three films revolving around everyday life in the improvised suburbs of Lisbon. In particular, *Bones* (1997) and *Vanda's Room* (2001) centered on the impending doom of the Fontaínhas neighborhood. Through the images of sustained stares, sounds of buses and stray dogs, Costa effectively captured the significance of a depressing and addictive banality. Despite his anthropological approach to casting and set production, Costa does not explain the Fontaínhas neighborhood in his triptych. Rather, as an aesthete, Costa imposes a sentiment of marginality. The role of Cape Verdeans and Kriolu is fleeting, a few sexual and moral encounters for the main actors to negotiate.[5] For the most part, Costa maintains the camera focused on Tina, Clotilde, and Vanda with Kriolu held at a distance. The transition to the Boba neighborhood during the filming of *Vanda's Room* was more than spatial, as signaled in the Costa quote above. The making of Boba involved the marginal element of Kriolu.

GHOYA'S KRIOLU CLAIMS

Ghoya moved to the "social" neighborhood of Casal da Boba in the municipality of Amadora in 2001 when he was fifteen years old. He had lived previously in Benfica municipality, in the improvised neighborhood of Fontaínhas.[6] The destruction of

Figure 27.3. Neighborhood of Casal da Boba in background. Traffic barrier with "Fontainha" graffiti tag in the foreground referring to the demolished neighborhood of Fontaínhas.
Photo by author, 2009.

Fontaínhas was part of PER (Special Program of Relocation), a project initiated in 1993 sponsored by the Portuguese state and European Union agencies to eradicate the "tin can 'hoods" (bairro de lata) from Portugal's main cities of Lisbon and Oporto by the year 2000. Many of the residents from the Fontaínhas demolition ended up in Boba (note the reference to "Fontaínhas" in figure 27.3). According to urban geographers such as Rodrigues (2003) and Vilhaça (2001), there was little to no consideration of the sociality of residential spaces in the transitional process. Floresbela Pinto, a public employee of the city division of urbanization and long-time resident of Quinta da Serra, an improvised neighborhood adjacent to the Lisbon international airport, explained to me that while the ideology is one of standardization, neighborhood transitions vary widely due to political and economic interests in the property. The main goal of PER was to relocate approximately 130,000 people, who were living in unregulated, non-standard, poorly serviced communities to places with infrastructure in the most efficient manner possible. And the operating logic was that standardized infrastructure would naturally create standardized citizens.

In October of 2009 during our conversation in Boba, Ghoya echoed much of what cinematographer Pedro Costa describes in his recollection of the relocation process after the demolition of Fontainhas.

> The experience here has been shit. You see these buildings? They're less than ten years old and you can see how they're crumbling. I mean, they didn't invest much in this. That's obvious. I'm old enough to remember Fontainha and that was tough, but we made that. People put that on the map. But, you know, it's not just that. The housing officials think that now it's all solved just because they made these white, cement boxes and call it new and then publish in the media that we are 'new'—meaning included folks. It's not true; there's no recognition. That's why you find young folks like me, Boss and dozens of others out here yelling and screaming. We're not interested in just asking for some help at the door; we're going to bust down the door so we can get some rights to make this place into our own.

Ghoya is not alone. In her analysis of Cape Verdean youth coping mechanisms during the first decade of the twenty-first century, Fernandes quotes one of the residential leaders from Boba.

> Improvement is not just about moving people. It's not just about holding soccer tournaments and parades. One has to accompany poverty. . . . When people lived in shacks [barracas] they didn't pay anything. Now, people are tenants and have high rents; they can't afford electricity or water. Among the elderly, there have been several suicides. No one looks into the causes . . . These buildings are four stories tall and have no elevators. The responsible agencies are enclosed in a government building, waiting for people to find them and knock on their door. They simply do not accompany what lived poverty is (in Fernandes, 2006, p. 42).

Obviously, people react differently to change in spatial organization of residential everyday life. While some take extreme measures, such as suicide, most try to adjust to what anthropologist James Holston termed an "interiorization" in his discussion of living in block housing units in the Brazilian capital city of Brasília during the 1980s (Holston, 1989). In my experience with dwellers in housing projects, especially those youth who come of age during the transitional years moving from an improvised, auto-constructed neighborhood to a barebones, cement block housing project, the dominant reaction to "interiorization" and social isolationism is to reinforce previous methodologies of forging social relationships in common public space (Pardue, 2008; Albuquerque et al., 2001). What was once done in the becos or the labyrinth of alleyways within shantytown living is carried out around the cement soccer court and in the nondescript cement courtyards between the residential buildings. Ghoya explains, "we start from the street. This is where we make ourselves. Ok, it looks different here in Boba than in Fontainha or wherever, but we make it work. That's one of the powers of Kriolu. We link Kriolu with rap to speak."

BOBA AS A KRIOLU SPACE

Here, Ghoya alludes to the unofficial but operational national language of Cape Verdeans on the archipelago and all around the diaspora. Kriolu is a language with

Figure 27.4. Graffiti on apartment building in Boba neighborhood.
Photo by author, 2009.

predominantly Portuguese vocabulary mixed with grammar and syntax borrowed from a host of West African languages. While some scholars have interpreted the prevalence of Kriolu in Lisbon as cultural preservation or a recreation of homeland life ways (Fernandes, 2006; Cardodo and Perista, 1994), my experience with young Kriolu rappers leads me to believe that Kriolu is a more complex sign of belonging. Certainly, Kriolu is about being Cape Verdean, but, in the case of Ghoya, members of his rap crew Afro Mentis, literally "Afro Mind," along with Sindykatos MCs, literally labor union MCs (see figure 27.4), and others to be discussed below, Kriolu is not necessarily about the place of Cape Verde. Kriolu is a meta-statement on the displacement and emplacement of postcolonial Portugal.

As I sat together with Ghoya and Boss on a cracked wall, Kriolu salutations of tud dretu from older speakers and modi from the youth ricocheted about bouncing off the concrete façades. Ghoya responded with a bellow. Kids yammer about rules of a game, an elderly man complains about the price of bread, and girls shout out commands for young males to go do this or that chore. Kriolu sonically differentiates Boba from the "social neighborhood" across the way of Casal de São Bras.

Yet, Boba is not, demographically speaking, an ethnic enclave. It is a state-sponsored working-class residential project serving over 1,500 individuals. Its distinguishing feature is age—the majority of the residents are less than twenty-four years of age. Many are not eligible for RSI, a type of Social Security, because they are either immigrants or part of informal and unregistered labor.[7] Boba consists of a variety of mixed-income apartments with a range in square footage and corresponding rental rates. Be that as it may, its public face is Kriolu. Ghoya's number one partner, Boss, put it this way:

> Kriolu is like that. We is we. Why suppress what is natural? Why not fill the air with the talk of your people? That's a good thing. In our own way [through rap music] we want to make Kriolu a Boba thing. Put Boba on the map. Right now you see people

> talk about Kriolu and us connected to the Linha Sintra. That's good. All these people. PALOP, migrants, gypsies and everybody else. We're making our mark.

Kriolu is a public code that articulates a special combination of place (diaspora, Lisbon, Amadora, cement plaza outside of an apartment building) and time (independence of former African colonies, postcolonial milieu of Lisbon, contemporary neighborhood, everyday life). If Kriolu is a cultural reification, an essentialized manifestation of identifications and differentiations located in names, places, and so on, as Pina-Cabral theorized in the opening quote of this essay, have Boba residents translated the spoken language into an identifying landmark? In other words, can the spatiality embedded in Kriolu through the experiences of moving become an item of patrimony in Amadora municipality?

Such an endeavor is certainly a challenge given the systematic treatment of Kriolu and migrants by cultural and historical institutions in the Lisbon area. It is not so much a proliferation of negative representations but rather a consistent perspective that cultural differences are secondary to social ones (Fernandes, 2006; Silva and Machado, 2010). Therefore, there is no need or value in giving institutional recognition to Kriolu culture as a collective mark of Boba.

According to the municipal government's official website, patrimony is a significant type of "culture." It is precisely where temporal and spatial dimensions of collective identity converge. In the case of Amadora, as it is in Lisbon more generally, patrimony is about two things: conservation and conduit. Amadora contains a few private homes traced to local founding fathers, investors, and missionaries. In addition, the municipality possesses a small number of architectural marks in the form of bridges and archways, placing Amadora in the pathways of civilization between Lisbon and Sintra, the UNESCO World Heritage site and point of Portuguese Catholic pride in the retaking of Iberia from the Muslim Moors.

The presence of Kriolu in peripheral social neighborhoods poses the question: can migration be patrimony? While in Boba, Kriolu and the more general experience of migration have yet to grow beyond a daily tenor of difference in relation to the concrete boxes of apartment complexes, the case of Cova da Moura provides an alternative model of neighborhood space and identity.

COVA DA MOURA

The case study of Kriolu in Boba demonstrates the spatial tensions in subaltern speech, as the impersonal cement boxes rub against local youth's desire to socialize and differentiate. In Alto da Cova da Moura ("Kova M"), youth are also present in great numbers and want to link talk to neighborhood landmarks. This is what youth call making cenas or "scenes."

Cova da Moura is a large, improvised neighborhood in the municipality of Amadora, located approximately two miles south of Boba. According to local mythol-

Figure 27.5. Moinho da Juventude cultural center, a landmark in Cova da Moura.
Photo by author, 2009.

ogy, Cova began with the end of Portuguese colonialism in 1974 represented by the implosion of the Portuguese military and the independence wars in its African colonies.[8] For four years thereafter, a gradual but consistent stream of day laborers, consisting of predominantly Africans and the white Portuguese, who were forced to return to Portugal from Africa (so-called retornados/"returnees"), sought out residence close to the automobile accessory factory of Martins and Almeida and various construction sites, which contributed to the boom in social neighborhood urbanization, as discussed above. In 1978 the municipality finally recognized Alto da Cova da Moura officially as a legitimate neighborhood, albeit improvised.

COVA SCENES: INSTITUTIONAL

The commuter train line that links Lisbon with Sintra, the so-called Linha Sintra, marks Cova's northern border. In this section I describe two different types of "scenes." The first is institutional, the landmark of Moinho da Juventude (see figure 27.5). "Moinho" can translate as "mill," a connection to a significant part of the Cape Verdean economy. However, perhaps the best translation of "moinho" in this case is to draw from the colloquial use of the term in the phrase, "to take the water to the mill," meaning to get the job done. The connotation here is more about achievement; therefore, one might understand "Moinho da Juventude" as an organi-

zation of youth achievement. The second "scene" highlights nighttime strolling and car cruising around the neighborhood. The significance of "scene" for the purposes of this chapter rests in its articulation of space and identity. Aspiring rapper, sound engineer, and community activist, Heidir explains,

> Kova M now is known for a lot of things. It used to be all about negative stigma related to drug trafficking and violence. Always something connected to being Cape Verdean. Over time, we stuck it out here. We built stuff like the Moinho da Juventude [youth and cultural center]. The places are important because they provide more space for us to make "scenes." It's about getting together, having fun but with real objectives. First, let me show you the crèche [daycare] and then I'll show you my favorite part—the Kova M studio.

Table 27.1 from the INE (Instituto Nacional de Estatística, Statistics Portugal) indicates various kinds of crime and their occurrences throughout the Lisbon-Setúbal metro area. The statistics and their interpretation help provide context to Heidir's sense of stigma regarding Cova's "scenes." Cova da Moura is one neighborhood in the municipality of Amadora, which along with municipalities of Loures, Almada, Seixal and Oeiras are the areas with the most PALOP immigrant population. While the numbers are somewhat elevated with seven to eight thousand crime occurrences during 2010, they pale in comparison with Lisbon proper and Sintra, a major destination of tourism due to the historic castles constructed during Portugal's golden era. Popular polls have made sense of such statistics by asserting that it is not just that Cova and other immigrant neighborhoods are dangerous areas in and of themselves; their residents also come to "our" districts and commit crimes.

Moinho da Juventude is a non-profit organization that employs ninety-four people. It began in the 1980s as a grassroots project to improve living conditions, health care, provide daycare, and professionalization workshops for the residents of Cova da Moura. Women have been particularly active and were the primary organizers. They mobilized the community to build the structures and give it a strategic location. Moinho stands at the peak of this hillside neighborhood. Economically, Moinho depends on a combination of local activities and outside funding to maintain operations. The former ranges from public performances of Cape Verdean popular dances, such as batuko and funaná, to studio rental to culinary festivals. Outside funding comes from European Union cultural agencies.

Beyond cultural activities the Moinho also provides sporadic health services, and as the chart below shows, the municipality of Amadora along with the other PALOP areas lack such public services. This is simply one indicator of the uneven attention these peripheral areas receive from the state. When there is an economic interest in urbanization development, PER and third-party investors are quick to act using the discourses of danger, violence and standardization to address marginalization and justify the urgency of intervention. However, upon scrutiny of the social indicators corresponding to a sustained infrastructure (health, education, transportation), the State and other actors are barely visible.[9]

Table 27.1. Offences Recorded by the Police Forces by Municipality According to Type of Crime, 2010

				Against patrimony							
					of which		Against life in society			Sundry legislation	
	Total	Against persons		Total	Theft/purse snatching and robbery in public	Theft of/in motor vehicles	Total	Driving a motor vehicle with a blood alcohol equal or higher than 1,2 g/l	Against the State	Total	Driving without legal requirements
		Total	Assault								
Portugal	424,150	96,729	63,847	224,752	16,016	61,428	50,700	22,067	6,212	45,741	18,886
Continente	388,006	88,806	58,654	215,598	15,708	60,124	44,662	17,737	5,391	33,533	16,473
Lisboa	132,641	25,977	17,842	78,637	10,029	22,293	13,054	4,764	1,998	12,972	6,404
Grande, Lisboa	99,357	18,896	13,040	58,719	8,001	16,829	10,247	3,862	1,553	9,939	5,002
Amadora	8,698	1,798	1,229	5,275	1,358	1,485	704	190	. . .	747	370
Cascais	8,667	1,889	1,241	5,109	404	1,899	746	271	105	818	481
Lisboa	41,276	5,894	4,081	26,052	3,304	6,806	4,630	1,779	. . .	4,218	1,709
Loures	8,264	2,048	1,428	4,224	649	1,127	934	330	203	855	489
Mafra	3,180	640	383	1,638	17	585	433	290	79	390	193
Odivelas	4,637	1,000	762	2,515	416	801	555	206	93	474	375
Oeiras	5,854	1,429	978	3,307	375	923	560	184	. . .	483	269
Sintra	14,706	3,125	2,240	8,517	1,300	2,634	1,308	481	276	1,480	905
Vila Franca de Xira	4,075	1,073	698	2,082	178	569	377	131	69	474	211
Peninsula de Setubal	33,284	7,081	4,802	19,918	2,028	5,464	2,807	902	445	3,033	1,402
Alcochete	723	137	93	439	13	134	61	12	3	83	42
Almada	7,431	1,538	1,008	4,435	517	1,340	608	168	112	738	321
Barreiro	3,201	795	546	1,912	303	517	169	53	36	289	93
Moita	2,589	622	437	1,597	163	446	194	40	23	153	44
Montijo	2,122	559	371	1,158	71	320	144	49	25	236	90
Palmela	3,115	535	330	2,028	85	382	280	91	37	235	171
Seixal	6,125	1,351	939	3,567	458	908	620	198	87	500	286
Sesimbra	1,962	386	254	1,180	51	359	236	80	29	131	66
Setubal	6,016	1,158	824	3,602	367	1,058	495	211	93	668	289

Adapted from: Ministry of Justice—Directorate-General for Justice Policy.

Table 27.2. Health Indicators by Municipality, 2009 and 2010

	2010			2009				
	Nurses per 1,000 Inhabitants	*Physicians per 1,000 Inhabitants*	*Pharmacies and mobile medicine depots per 1,000 inhabitants*	*No. Hospitalisations per 1,000 inhabitants*	*Major and medium surgeries per day in health establishments*	*Medical appointments per inhabitant*	*Beds (practised allotment) per 1,000 inhabitants at health establishments*	*Annual bed-occupancy rate in health establishments (%)*
Portugal	5,9	3,9	0,3	113,9	2 513,6	4,0	3,4	77,5
Continente	5,8	4,0	0,3	113,6	2 448,9	4,1	3,2	77,7
Lisboa	6,1	5,4	0,3	134,6	780,1	4,5	4,0	78,9
Grande Lisboa	6,9	6,6	0,3	158,0	675,4	4,7	. . .	. . .
Amadora	5,4	3,0	0,2	. . .	. . .	. . .	. . .	. . .
Cascais	3,9	7,0	0,2	75,0	26,8	3,3	2,4	77,9
Lisboa	20,9	17,0	0,6	502,6	523,8	10,9	14,1	76,5
Loures	1,5	3,8	0,2	. . .	. . .	. . .	. . .	. . .
Mafra	1,2	1,7	0,2	0,0	0,0	2,3	0,0	0,0
Odivelas	2,0	2,5	0,2	0,0	0,0	1,7	0,0	0,0
Oeiras	4,0	8,6	0,3	. . .	. . .	. . .	. . .	. . .
Sintra	1,4	1,7	0,1	4,7	0,0	1,9	2,5	86,3
Vila Franca de Xira	3,3	1,3	0,2	69,6	9,5	2,6	1,5	91,2
Peninsula de Setubal	4,3	2,4	0,2	. . .	. . .	. . .	. . .	. . .
Alcochete	1,4	2,0	0,2	0,0	0,0	2,4	0,0	0,0
Almada	7,4	3,8	0,3	157,4	36,1	5,3	3,6	84,4
Barreiro	7,6	2,6	0,3	. . .	. . .	. . .	. . .	. . .
Moita	1,7	1,0	0,2	0,0	0,0	2,9	0,0	0,0
Montijo	4,2	2,3	0,3	39,9	2,5	2,9	1,7	70,6
Palmela	1,4	2,1	0,2	0,0	0,0	2,9	0,0	0,0
Seixal	1,6	1,4	0,2	0,0	0,0	2,6	0,0	0,0
Sesimbra	1,3	1,2	0,1	0,0	0,0	2,3	0,0	0,0
Setubal	7,0	3,6	0,2	. . .	. . .	. . .	. . .	. . .

Adapted from: Statistics Portugal, Statistics on Health Establishments, Health Personnel Statistics, Pharmacies' Statistics Demographic Statistics, Provisional Estimates of Resident Population, recomputed from the final results of the Census 2001 and adjusted to coverage ratios.

Note: The item "Physicians per 1,000 inhabitants" considers the place of residence. The item "Nurses per 1,000 inhabitants" considers the place of occupational activity. From 2006 on, statistics on surgeries refer exclusively to hospitals.

Heidir knows about a variety of "scenes"; he had been in prison for over two years for drug trafficking before we met in 2009. His brother was sentenced to five years. While in prison, they wrote pages of lyrics, and soon after he returned to Kova M, Heidir spent as much time as possible in the new confines of the Moinho recording studio. He saw it as a "platform to make a scene." Heidir inserted his USB pen drive, cued up the studio control board, and made the desired adjustments for bass and volume. He signaled for me to sit beside him and soak up the sounds and lyrics. We listened independently to the seven-minute song. It was intense; Heidir never once looked at me. While he mouthed his lines and bobbed his head to the pounding downbeat of the bass drum, I stared at the lone microphone in the insulated recording room. I thought about amplification and platforms.

> You see. That [the song] right there is drama. It is real experience. It is straight up Kova M. You know, outside of the neighborhood there are few options for us. Few people really move away because we end up finding something in our immediate surroundings that we connect with and make into something . . . a living. For me and many others, it was drugs. But that is a dead end. Cova da Moura has more scenes. That's a good thing. For me, rap and even more to the point, Kriolu rap is a good scene. There are two types of songs for me—drama and party. Drama, like the song I did with my brother right there, is real; it's about learning. It's fact. It's not about celebrating violence. It's just fact. Party is about celebrating Kova M; it's about pleasure and the spots I showed you during the Sabura tour.

That Kova M studio is a landmark and a scene is not a secret. Most rap sung in Kriolu in the Lisbon area is produced in Kova M, and increasingly more "tuga" rappers—the general category for Portuguese rap—are embracing Kova M as a respected hip hop landmark. In addition, state cultural agencies such as Programas Escolhas, an organization that works with immigrant youth regarding issues of citizenship, education, and employment, has sponsored sound engineering workshops and rap contests linked to Kova M.[10]

Towards the end of his comments, Heidir referred to a tour called "Sabura." This Kriolu term can act as a segue into a discussion of the second Cova da Moura scene—weekend night leisure. "Sabura" means joy or happiness and thus serves well in song lyrics ranging from pop to high art poetics. Like many Cape Verdean Kriolu words, "sabura" contains a Portuguese root, with which local speakers over time have developed and created a new phonemic and morphemic cluster. In this case, "sabura" comes from "saber," the ubiquitous verb "to know." With "sabura" nothing can go wrong; it is about knowing that everything is under control and harmonious. "Sabura" is the substantive form, while "sabi" or "sabim" is the adjective form. These words not only enhance forms of popular culture, they also function effectively as a name for many Cape Verdean businesses or cultural projects. This latter use is pertinent to Heidir's comments.

In one of his many roles, Heidir leads small groups of "outsiders" on the "Sabura" tour around Cova da Moura to visit restaurants and family-owned clothing and

accessory shops. All the while, Heidir recounts a version of Cova history highlighting the camaraderie and community feeling. I had contacted Heidir the previous week, and we scheduled a tour. With the visibility of "favela tours" from Rio de Janeiro, Brazil, on my mind, I was curious to see how the Moinho cultural center, in this case, selected and commodified the Cova da Moura neighborhood space. I also was cognizant of the criticism by some Kriolu rappers in other improvised and "social" neighborhoods that "Sabura" treated the neighborhood and Cape Verdeans like a zoological expedition. Chullage, an outspoken community activist from both improvised and planned residential projects on the "South Margin" of the Tagus River and a popular rapper, had expressed to me over the phone, "Why do they [folks in Cova da Moura] do that Sabura thing? I wouldn't want that here in Arrentela. I don't want people coming around looking at me like I'm some caged animal. If you have interest, just come to our Associação Khapaz [local cultural center] and we're happy to chat about the neighborhood or whatever. A tour? I'm against it."

Chullage was right. The visit was far from natural. Nevertheless, it provided an opportunity for me to get to know Heidir. Over lunch, the capstone of the "Sabura" tour, Heidir relaxed a bit and we discussed Kriolu rap, Cova da Moura on the weekends, and the nighttime happenings of the neighborhood. I asked Heidir about *Esperança* (full title: "Hope is where you least expect it"), a Portuguese film targeted to teenagers. The film tells a story of a "tuga" or white family's fall from grace and class standing, which forces the son to attend a public school populated predominantly by students of Cape Verdean descent. Unsurprisingly, the film culminates in a challenge of masculinity and a crossover romance with a local girl. Some of the scenery looked familiar to views in Cova, and I had noticed a promotional poster for the film in the Moinho center. Heidir smiled and took pride in stating that he was, in fact, in three scenes, albeit as a drug trafficker. Indeed, there were several scenes shot in Cova da Moura, and overall was a positive portrayal of Kova M.

Two groups of young men, huddled around their respective tables devouring the hefty mound of katchupa or hominy stew with beans and meat or fish, listened in and quickly interjected their opinions about the film and the role of Kriolu. Prideful of their local knowledge and concerned that Heidir would monopolize the story of "Kova M," the young men began to crowd around arguing about this song and that artist, this local café and that funaná band. Finally, we agreed that I could come back on a Saturday night and meet everyone at the corner café of LBC's mom.

KOVA M SCENES: JOY RIDING

I arrived and decided to climb the main road and not take my chances trying to navigate the labyrinth of alleyways Heidir and LBC had shown me in prior visits. After the first fifty meters, I heard nothing but Kriolu. Kids of all ages, young adults and a few elderly folks were out in the streets. People were simply hanging out, sitting on steps, visiting friends, and making plans. The initial cena ("scene") was at the

café owned by LBC's mom. Dona Anastácia welcomed me and told me to stay, as a funaná band would shortly begin to play. Young men had already occupied the tile-covered balcony. They were drinking sodas, playing cards, and talking soccer. Alyson, a twenty year-old rapper and recent immigrant from Santiago island of Cape Verde, impressed the men with his stories of the capital city of Praia and the rough nature of living through droughts. He battled rhetorically with Simão, who was in town from the popular Cape Verdean diasporic community of Rotterdam, Holland, to visit his mother and sister. Their banter consisted of tales of labor and life back at "home" in Cape Verde and in a popular diasporic destination, Rotterdam. The small crowd egged them on and eventually drowned out Alyson and Simão expressing that "now, you all are here—the heart of Kriolu in Portugal. This is Kova M. Yeah!" LBC and Heidir greeted virtually everyone who passed by on the street. They were waiting for a local rapper, as he had promised to pass along a USB pen drive containing a new beat track that people could use in the Kova M studio at Moinho.

Finally, Kriolu rapper Kromo turned the corner, and LBC and Heidir called him over. In response to my queries about the significance of rapping in Kriolu, Kromo stated: "Kriolu is not a difficult language [in and of itself], it's all in the manner of speaking . . . it's a way of being." Kromo's life story flows against the current of Heidir, LBC, Ghoya, Boss, Chullage and many other Cape Verdean descendants living in Lisbon. He grew up in Alfama, one of the first working-class neighborhoods in Lisbon. As discussed above, Alfama represents one of the historic districts of Lisbon, a prominent landmark of Portuguese cultural patrimony. This is made manifest primarily through taverns featuring "authentic" fado music. Kromo and his mother moved to Cova da Moura in the face of elevated rents in Alfama but also, according to Kromo, because "we knew we would feel comfortable, recognized, and even respected in Kova M. That was major."

As one can imagine from the photograph in figure 27.6, Cova da Moura is not an easy place to drive with streets so narrow that cars can barely get by all the people who are seemingly always out. Pragmatically speaking, it makes no sense to drive there. Similar to the much larger shantytown complexes in Brazil, Nigeria or Mumbai, neighborhood transportation is best on foot with a knowledge of the becos or alleyways. However, car travel is actually important in Cova da Moura, as those of some means enjoy cruising around. Cars become mobile stages for individuals and groups with reputations to amplify what Heidir called "party" or leisure life, as opposed to "drama" rap.

Such joyrides occurred on a few occasions in 2009 and again on a recent visit in 2011. Heidir hailed me, LBC and Kromo over to his car and we took off. I realized that our cruising around curves, logistically going nowhere, was part of the game that included swerving, yelling out to everyone, and pumping a mix of Kova M studio Kriolu rap and the latest tunes by Lil' Wayne and Kanye West. Heidir turned on the twelve-inch LCD screen and cued up a series of Jay-Z, 50 Cent, and Black-Eyed Peas videos. In effect, the videos doubled as inside entertainment for the passengers as well as a complement to the interior and exterior lighting of the car. We glided by bumping and illuminating trails in the neighborhood—a party pod in the name of Kova M.

Figure 27.6. View of main paved entrance into the neighborhood of Cova da Moura, as seen from Damaia/Santa Cruz train station.

Photo by author, 2009.

CONCLUSION

While in the United States public opinion continues to reckon the "project" as a vertical slum, a negative residue of modern architecture, and an obsolete form of urbanization, in Lisbon, as is the case in many other parts of the world, the project or "social neighborhood" is a primary response to the conditions of postcoloniality made manifest in migration demographics and the reorganization of labor.

My focus on Cova da Moura as an example of the auto-constructed community is not an unproblematic nostalgia of simply the good old days of owning property. The great majority of improvised neighborhoods lack adequate basic services of sanitation, electricity and infrastructure. They can be dangerous, and residents often face stigma in school and attempts at employment.[11] However, there exists a level of control over the meaning and shape of the space that differentiates the improvised from the social neighborhood. Part of that "control" involves a routine of neighborhood sociality or vizinhança with learned habits of negotiating domestic and public spaces (Cardoso and Perista, 1994).

In the case of Cova da Moura or Kova M, residents have congealed around a notion of Cape Verdean ethnicity as an internal theme for spatial and economic development, as seen in the "Sabura" tours, cinematic participation, and the construction of and activities around the Moinho da Juventude cultural center. In addition, youth, in particular, invest in the spatiality of leisure through car cruising. What is clear from my account based on a few weekend nights in Cova da Moura above is that Heidir's car functioned not only as a vehicle for his own ostentation but also as a floating sign of Kriolu. Kriolu is both a diasporic reminder of Cape Verde and an intended signature on urban Portugal. This is a point of identification where everyone is more or less on board.

I am not arguing that urban planners should address postcoloniality with ethnic enclaves. That may be one logical response, as is, in part, the case with Cova da Moura. However, the larger idea is that municipal agencies of housing should recognize the power and investment of identity in the making of home and neighborhood and thus facilitate its articulation. Simply demolishing impoverished, auto-constructed neighborhoods and relocating its residents in superficially modern efficiencies is not a panacea to urban blight. Just as Pruitt-Igoe project in St. Louis during the 1960s and 1970s did not resolve the social inequalities of ghetto life, underemployment and racial/ethnic stigma (see Freidrichs, 2011), the project of Boba has not ameliorated what the Portuguese press and scholars term "social exclusion."

What is left is agency, or what Cardoso and Perista describe as "participation" (1994, p. 110), that life path dynamic of connecting self to recognized social structures. For bourgeois neighborhoods of Lisbon "culture" (Baixa, Alfama, Bairro Alto, etc.), state and corporate entities recognize and invest in neighborhood identity. In fact, they capitalize on it through a particular reading of urban history, as sketched out above. Residents benefit indirectly, at the very least, by such associations. Here,

street life is generally public. Similarly, some new neighborhoods, such as "Parque das Nações," the result of land appropriations and high investment and development in preparation for the 1998 World Exposition, benefit from an identity born from class exclusion (Sieber, 2007). There is no urgent need for residents to organize and create collectivity; their relationships can rest comfortably and naturally at the level of what Jane Jacobs once called "sidewalk familiarity" (Jacobs, 1961). Nevertheless, people inevitably find ways to "speak," in the sense of De Certeau's emphasis on the phatic dimensions of "walking in the city" (1984, pp. 98–100, see also Sieber, 2007), and it is toward this sort of articulation between space and identity that anthropologists and urban policymakers alike need to focus analyses.

The evaluation and modification of space cannot be divorced from social histories of state agencies nor cannot it be separated from the social capital of local actors' practices of occupation. Ultimately, the examples of Boba and Cova da Moura demonstrate the spatial ramifications of what historian Robin Kelley (1997) once called the "politics and pleasures" of hip hop. Kriolu rap in Boba is an outburst of conflict, a rage against the machine. In Kova M rappers also adopt this tone with respect to issues of employment, education and immigration. However, they speak from more solid ground, and the socio-spatial achievements of Cova da Moura afford an articulation of Kriolu to the pleasures of tourism, café life, daycare, and parades. In the words of Heidir, there are simply many more "scenes" in Cova da Moura. While in Boba residents are consumed with everyday struggles for control of their surroundings, as they make do with substandard, subsidized environments, residents of Kova M did struggle with the state for official recognition, continue to combat stigma against Cape Verdeans as "dangerous immigrants," have survived the wave of demolition, and enjoy their maverick identity.

For the social scientist and the urban planner, the ethnographic cases of Kova M and Boba demonstrate that space is an essential element in identity formation because it is part of social history; in this case, histories of labor, modernity, and postcolonial migration. Furthermore, the fact of territorial possession or leasing is not equal to the occupation of space. It is through occupation that people invest value into space and are more or less recognized by the state as contributing to city or national "culture." The presence of Kriolu still does not resonate with the Portuguese state in any systematic way and thus reveals part of the discontent in postcolonial Portugal. Such case studies as this one provide insight into a global phenomenon—the spatial dimensions of postcolonialism and corresponding structures of value and patrimony.

NOTES

1. All translations from Portuguese to English done by author unless noted otherwise.
2. See, for example, Castells (1979), Meade (1997), Massey (1994), Holston (1999).
3. See Bell and Jayne (2004), Ifekwunigwe (1997), and Sassen (2001) on the role of migration in the contemporary formation of various global cities.

4. All the maps and charts in this article were taken from INE (Statistics Portugal) from census of 1981, 1991, 2001 and 2010. http://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine_main.

5. One of the only other films depicting neighborhood demolition in Lisbon is *Outros Bairros* (*Other Neighborhoods*) by Kiluanje Liberdade. In contrast to Costa, Liberdade focuses on young Kriolu residents, some of whom would later become important rappers in the Lisbon scene.

6. The official spelling is "Fontaínhas," but on multiple occasions residents referred to it as "Fontainha." I simply maintained the difference as per the speaker's choice.

7. This demographic information comes from the Amadora Municipal archive called the "Social Diagnostic of Boba" (Diagnóstico Social da Boba) published in 2005, accessed in October of 2009.

8. According to Horta (2008, pp. 184–85), the actual history of Cova starts in 1940 with rural, white migrants in search of arable land.

9. The conflicts between PER and residents of improvised neighborhoods in Amadora continue to spark controversy. In July of 2012, armed police entered into Santa Filomena neighborhood in Amadora to physically expulse 285 residents for not being registered in the PER program, the majority of whom are unemployed and resident since before 1993 or are displaced school-age children. As the police expelled the residents, bulldozers demolished the improvised housing. See, for example, http://www.habita.info/2012_07_01_archive.html.

10. See the article in *Fórum Escolhas*, no. 12 (July 2009): 43–44.

11. For example, see http://www.noticiaslusofonas.com/view.php?load=arcview&article=23893&catogory=news, which provides a journalistic report about the violence between the improvised neighborhood of Bairro da Jamaica and the social neighborhood of Quinta da Mata in the "South Margin" municipality of Seixal.

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28

Exploring the Social Outcomes of Brownfield Regeneration in Different Types of Deprived Communities

Evidence from Manchester, England

Jennifer P. Doyle

This chapter considers notions of social capital to investigate to what extent the social ambitions of the brownfield agenda have been reached in England. One key rhetoric of this evolving agenda is that new residential development on brownfield sites within deprived communities will attract 'new households with greater social capital . . . enhancing social, economic and environmental sustainability in one strike' (Mace et al, 2007, p.3). Using neighbourhood specific development (NSD) typologies, this chapter uses case study findings from deprived urban communities in Manchester, England, to consider the social capital effects engendered by brownfield residential development. Key findings are presented thematically, with analysis reflecting upon the case studies and the social ambitions of the brownfield agenda. The chapter concludes with reflection upon the need for greater exploration into social change within deprived areas of England.

BROWNFIELD SITES IN ENGLAND

The English economy boomed during the eighteenth and nineteenth centuries, with factories and mills establishing operations in many towns and cities to feed the demands of the Industrial Revolution. Urban landscapes became dominated by both industrial uses and high-density housing for workers. Economic restructuring since this time has led to declining manufacturing industries in England. This decline can be seen in two key ways: industry relocation whereby industries relocate to maximise profits, and the changing nature of industries themselves resulting from innovative operations. 'Although much of the present stock is attributable to the closure, downsizing or relocation of manufacturing industries, the discontinuation and changing requirements of other activities are also contributory factors' (Syms, 2010, p. 302).

One result of the economic restructuring witnessed in the latter half of the twentieth century in England is the disuse or dereliction of previously developed sites. Significant stocks of previously developed sites are located in the formerly industrialised towns, cities and regions. In the English context, 'brownfield' refers to any such previously developed site, regardless of its contamination status.

During the Industrial Revolution, towns and regions became known for their specialism—Sheffield for steel, Nottingham for lace, Staffordshire for its potteries, to name just a few. The spatial distribution of brownfield land loosely reflects those local and regional economies which previously specialised in highly specific industries. Maximising the economic upswing in particular industries at the time, many economies were dominated by just one or two key industries. Historical associations with formerly dominant industries may remain, yet the economies associated with these industries have eroded. As an example, the ceramics industry in North Staffordshire, despite declining productivity towards the late twentieth century, has maintained a hybrid economy consisting of small- and medium-sized firms alongside a few large firms (Sacchetti and Tomlinson, 2006). Whilst Staffordshire remains the centre of the ceramics industry in England, the overall output of the industry has declined. The regional economy's leading edge is only in comparison to the rest of England, and the Staffordshire pottery industry is no longer the world leader. Ceramics manufacturing has been largely outsourced globally from England, following firms going into administration. Waterford Wedgwood was sold in February 2009 to a US firm, which promptly outsourced 'the lions' share' of manufacturing operations to Indonesia, and it has since reported good performance (British Broadcasting Corporation, 2009a, 2009b, 2009c).

As a second example, the deindustrialisation of Sheffield takes a different form. Whilst employment in the formerly dominant industry of steel production and working has significantly declined to represent only a marginal section of the population, output has not declined to such a dramatic extent (Tweedale, 1993). Technological advances and the changing requirements of manufacturing require significantly fewer bodies to perform similar outputs. Sheffield remains an important location for the steel industry, though this takes a significantly different form to that which produced the Steel City of the Industrial Revolution. Similarly to the North Staffordshire example, economic restructuring in Sheffield has led to a proliferation of brownfield sites formerly in use supporting manufacturing industry. The former manufacturing centres of the north were disproportionately affected by deindustrialisation, and this is today where the highest stocks of brownfield land remain.

The impacts of de-industrialisation are multi-faceted, complex and far-reaching. Contemporary volumes of brownfield stock in these formerly industrial locations represent a physical manifestation of the far-reaching impacts of economic restructuring. This is particularly resonant in the case of hard-core brownfield sites; sites which have been left disused or underused for extended periods of time with latent development potential. Where long-term economic decline plagues local areas and regions, sites become less attractive to developers and the areas suffer the dual prob-

lems of deprivation and an inability to draw regeneration proposals. Later in this chapter we will explore the environmental, physical and social impacts of developing these less viable sites. The following two subsections consider existing market pressures and the spatial influence of greenbelt policies on urban built environments.

Economic and Residential Pressures on Developable Land

'Economic fortunes are cyclical, and so one may reasonably expect the temporal and locational occurrence of brownfield sites across England to reflect this. Where economies over-specialise in particular sectors these regions or localities become comparatively more vulnerable to the effects of economic restructuring. As demonstrated through the relationship between the former industrial centres of the England and existing locations of brownfield stock, over-specialising local and regional economies can lead to prevalence of derelict sites' (Hall, 2012, p. 84). Yet the Industrial Revolution in its heyday was arguably the most economically successful period in English history; whilst operating under the sustainability agenda, contemporary economic development is largely concerned with innovative development to spark 'the next industrial revolution' (Senge & Carstedt, 2001, p. 1). 'Regional competition in the twenty-first century is on a wider scale, a global scale—the odds of success are significantly reduced—and in a bid to increase the potential for a position as an economic 'winner', [English] development objectives are concerned with enabling innovative behaviour to catalyse the next long wave of economic growth' (Hall, 2012, p. 84). Regeneration initiatives in England then have dual ambitions: firstly, to ameliorate the effects of economic downturn, and secondly, to regenerate in accordance with economic development objectives. Former industrial sites are a significant resource which must be effectively and efficiently used if these ambitions are to be met.

Beyond the demands of economic development objectives, other factors influence the re-use of brownfield sites. Demographic and lifestyle changes have led to demand for increasing volumes of residential units in an already densely populated country. Supply has not as yet kept up with this demand, and house prices have become prohibitive to home ownership for many not already on the 'housing ladder'. Until recently, housing development was prescribed at the national level, guided by the regional level and targeted for the local level. This operated by placing demands upon local authorities to produce specific volumes of residential units per year to increase supply to meet consumer demand. This approach was dismissed by some as simplistic and unrealistic—moreover, it did not work (Gordon, 2009). Local differences in the availability of suitable development sites and the influence of the greenbelt, alongside local variations in housing market demand and uncertainly within the economy, compounded the complexities around and inefficacy of these top-down policies. Emerging policy, under a new coalition government, seeks to enable a bottom-up, local-level approach to try to address such local sensitivities and engender more effective regeneration. However, the problem remains that there is a national housing shortage. The public sector alone seems incapable of addressing

this problem, and the private sector is hindered by the economic climate as well as development policies. Greenbelt policies are often blamed by developers as a key factor preventing the increased supply of housing to the market, by restricting access to developable land to less viable brownfield sites. The next subsection considers the effects of the greenbelt on urban areas and regeneration.

The Greenhouse Effect of English Greenbelt Policies on Urban Areas

Despite the recent economic downturn (since July 2007), predicted demand for residential dwellings has increased. 'Given these upward revisions to projections, the balance of risk is towards a greater under supply of housing in the future' (NHPAU, 2009, p. 6). Development, then, must serve not only to meet economic development aims but must also meet future residential demands. The potential for local authorities to meet these demands relates to the availability of suitable development sites; the existence of viable brownfield sites for redevelopment or the potential to develop on greenfield sites. In England, greenbelt policies prevent development on greenfield, or previously undeveloped, sites in order to 'protect the countryside, be it in agricultural, forestry or other use' and to 'assist in urban regeneration, by encouraging the recycling of derelict and other urban land' (DCLG, 2006, p. 5). However, the limits on development imposed by greenbelt policies have different impacts in different areas.

As has been highlighted earlier in this chapter, there are spatial variations in both the volumes and type of brownfield land available for development. Northern, formerly industrialised cities tend to have higher levels of deprivation as well as higher stocks of brownfield sites (Hall, 2012). These more deprived areas also tend to have higher stocks of hardcore brownfield sites. In economically buoyant areas, particularly in the South East and around London, deprivation still remains present and important, but there are lower levels of deprivation, there are lower stocks of brownfield sites and there are fewer hardcore sites. Yet these Northern and Southern/South-Eastern cities are similarly constrained by the Greenbelt. The difference, of course, is the existing economic status of the city; the greenbelt raises the value and protects land inside existing urban areas and creates and economic greenhouse effect.

In deprived parts of the North, where brownfield sites are available, the greenbelt does make it necessary for developers to use previously developed sites despite them being potentially less economically viable and less attractive; this is reinforced through the National Brownfield Strategy (English Partnerships, 2007). The overall greenhouse effect this creates nurtures the redevelopment of declining centres by ensuring that development is targeted in declining areas. In contrast, in some areas of the South developers have largely used up stocks of brownfield sites, despite regeneration costs, because of the high viability of these sites. The greenhouse effect of the greenbelt here has created a very highly pressured and demand-intensive developmental environment whereby land and house prices are extraordinarily high and totally unaffordable to the vast majority. Land is all but exhausted, but demand

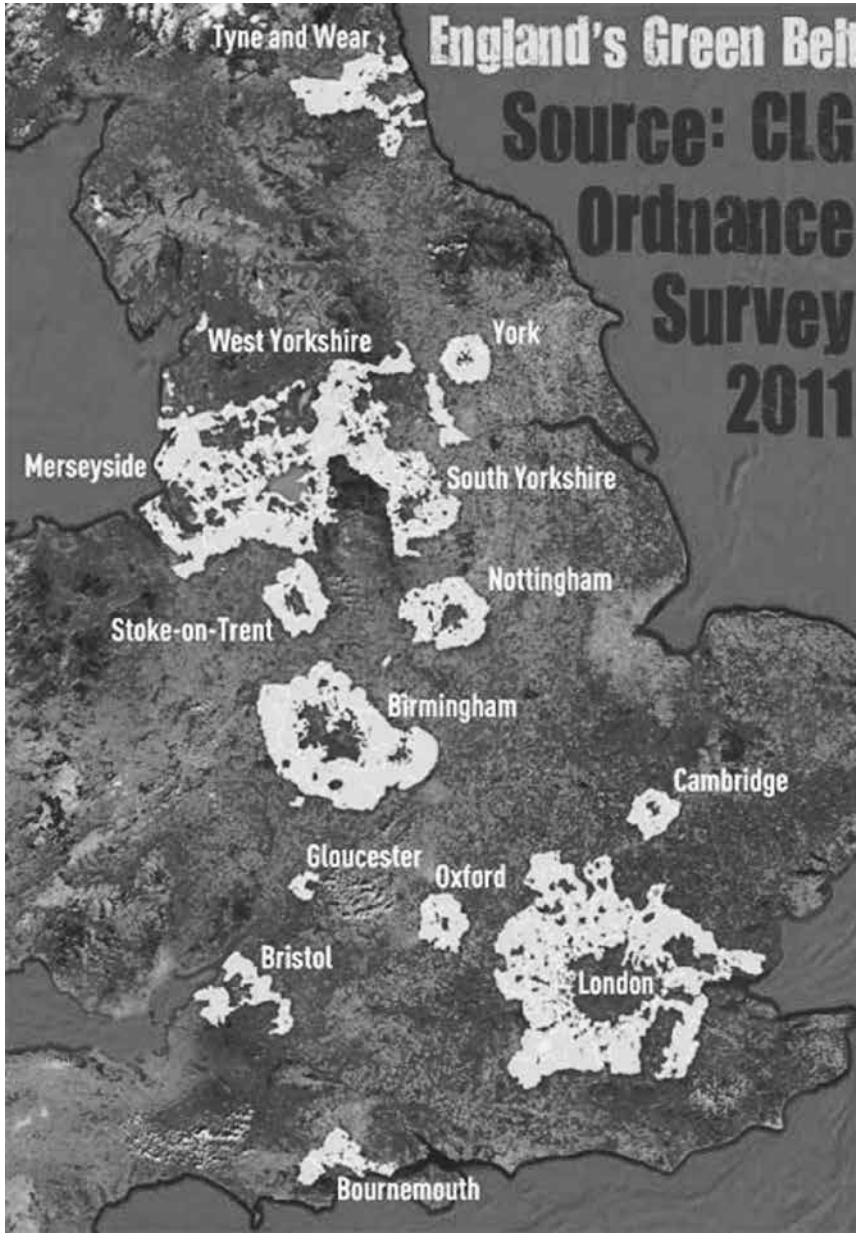

Figure 28.1. A map of England's greenbelt, which shows how the greenbelt operates to contain urban areas.

Source: Rae, 2012.

continues to rise and the greenbelt affords no release—this is the extreme of this greenbelt greenhouse effect.

There are arguments for and against changes to greenbelt policy, which are superfluous to this chapter but in of themselves are very interesting (Aldred, 2010, CPRE and Natural England, 2010). Towards relieving the pressure on London and the South East, certain public services, such as the government department and the British Broadcasting Corporation, are already in the process of decentralisation away from London and the South East to more affordable areas. This promotes employment opportunities and developmental interest in less buoyant local economies. It is difficult for employees to access public sector work where the local housing market is unaffordable; decentralisation offers more of the workforce opportunities to access employment in this sector. It may also attract people to move into these areas, stimulating local housing markets as people move towards work. However, regeneration through processes of decentralisation is not the norm and should be seen as an interesting anomaly rather than a wholesale solution to resolving the tensions between greenbelt policies and the regeneration agenda. Despite well-publicised efforts to move contemporary industries towards peripheral urban areas in addition to local and regional regeneration activity, significant levels of deprivation persist in many post-industrial cities. This chapter is concerned with investigating the social impacts of regeneration activity: if deprivation persists regardless of regeneration efforts, what then *are* the social effects of such development? The following section considers the extent to which urban developments can be said to influence social behaviour.

Considering the Relationship between Urban Development and Social Behaviour

The relationship between individuals and communities became a significant focus of research towards the end of the nineteenth century as Britain entered a period of rapid urbanisation. Processes of industrialisation demanded significant workforces to populate factories, and workers were attracted to the industrial cities. These cities were spatially structured, with industry dictating both the physical form of the city and who lived where. Urban social geography emerged at this time as philosophers sought to 'understand the social and psychological implications of [the] urbanism and urbanization' (Knox and Pinch, 2000, p. 208). The nucleus of interest in urbanisation was the relationship between scale of society and moral order. Traditional lifestyles outside of the industrial cities created small communities of individuals living similar existences with similar interests and experiences, and thus similar values and behaviours. The amalgamation of migrants from different areas into the cities brought together vast numbers of individuals with different interests and experiences. Industrialisation created communities of individuals with dissimilar values and behaviours. The size, density and differentiation of populations as a result of urbanism create the social and psychological consequences of city life (Wirth, 1969).

In the industrial city individuals had access to many more social ties than previously. These ties were weaker than and at the expense of the quality of primary

ties (family and close friends). The substitution of primary ties for weaker ties of increased volume results in a lack of social support in times of crisis. Behavioural adaption to city life buffers interpersonal relationships by way of protection in a new environment. Urbanisation and the new organisation of social ties it generates leads to 'an increase in the incidence, on the one hand, of social incompetence, loneliness and mental illness, and on the other, of deviant behaviour of all kinds; from the charmingly eccentric to the dangerously criminal' (Knox and Pinch, 2006, p. 209).

Social change results from the increased size, density and heterogeneity of urban populations (Wirth 1969). The spatial arrangement of neighbourhoods is dictated by industry, economic forces and the division of labour. This creates disparate individual social circles where social life is acted out in unrelated spaces and with unconnected individuals. The breakdown of social order is reinforced by the differentiated interests and behaviours of citizens. Lacking norms of behaviour, institutional intervention is employed to create and maintain an artificial social order. The result of all these effects may be a moral code so tangled and lacking in transparency that individuals enter a state of anomie; challenging or ignoring the enforced norms as a form of deviancy (Wirth 1969).

The ability of the individual to influence social order in industrial societies is moot. Durkheim argued that social order is maintained through the transformation of social solidarity into a manner beneficial to both the individual and wider society. This transformation may be attributed to the division of labour (Durkheim, 1893; Massey, 1984). Industrial location patterns created spatial segregation of specialised workforces. This produced the most appropriate workforces to perform industrial activity, as well as establishing new communities comprising individuals with similar behaviours. The spatial division of labour created new forms of social solidarity adaptive to modern industry. One example of this is union activity seeking to secure the fair pay and working conditions for employees. Industry creates spatial divisions of labour, from which evolves social organisation in the form of union activity. In this way, industry permits a route by which the individual is able to influence social order.

The modern era of industry was characterised by Fordist production methods; the breaking down of manufacturing processes into simple, repetitive tasks in order to speed up and regulate production. The products of modern industry in addition to changing divisions of labour influenced social life. The advent of the private motor car permitted individuals to travel freely to leisure and employment opportunities. Freight by road developed as a less expensive means of getting industrial goods across from the factory to the consumer. Individuals' norms and behaviours continued to adapt to technological advances. These advances created new ways of carrying out routine behaviour in faster and more passive ways. One example of this is the development of domestic washing machines which allowed households to clean clothes more quickly and with less effort than previously. Time became available in which to develop other behavioural norms—leisure activities. This period is often used to illustrate a historical point in time when individuals and communities devoted

greater time to social activities and the conscious production of community cohesion (Putnam, 2000).

Processes of deindustrialisation in the late twentieth century involved ongoing changes to social life. The rising costs of the workforce in developed countries in conjunction with technological advances led to a sharp decline in the demand for manufacturing employees in Britain. Recovering from an economic depression, the UK's economic base was rebuilt in the 1980s on the service industry and the privatisation of many public bodies. The post-Fordist production of capital has altered both the structure of cities and the spatial and social division of workers.

Residential patterns influenced by historic divisions of labour were largely exacerbated in the UK during the 1970s and 1980s, when many of those who could afford to leave city centres did. Urban renaissance programmes across the UK, originating in the 1990s, sparked new interest in and demand for city centre living. Clever marketing of new residential developments in formerly industrial areas saw large populations move back into city centres. Arguably this was through gentrification processes which pushed those who were already most vulnerable and living in city centres out of areas they could no longer afford. Those who were pushed out would need to adapt to new social situations in other areas and assimilate into those communities' norms of behaviour in order to thrive socially. For the new residential areas of city centres, there was no established social solidarity or social behavioural norms due to a lack of existing community; it has already been argued that this may create states of anomie within these new residents detrimental to social order. The following subsection explores the role and operation of cohesion in the contemporary city.

Cohesion in the Contemporary City

> The contemporary city can be seen as the product of changing economic organisation, reflecting the social relationships inherent in these changes, moulded by the prevailing means of transport, and continually reshaped by public policies (or lack of them) and personal lifestyles which stem from the dominant spirit of the age (Knox and Pinch, 2000, p. 31).

Socio-economic and political influences are played out on both national and international stages to create local demographic change. '[Such] change as it is nowadays observed in many developed countries is largely unprecedented' (Hamm et al., 2007, p. 1). Many studies into social change are concerned with the statistical makeup of individuals which form a community, for example, their ages (see Hohn et al., in Hamm et al., 2007) and their economic position in the global market (see Birdsall et al., 2003). A society or community, however, is greater than the sum of its individuals; other features or qualities of communities exist which have the potential for significant influence over individual behaviour (Kawachi and Berkman, 2000). Demographic change inevitably impacts upon these other features and qualities held by a community. Contemporary research into social change and social cohesion investigates these less tangible features or qualities and their societal impacts (see Ke-

arns and Forrest, 2001, and Kawachi and Berkman, 2000). Rather than considering the individuals and groups which add up to form a community, focus has shifted to consider the role, function and nature of that which binds us.

In recognising that a community is defined both by its members *and* their communal behaviours, one accepts that there is a value associated with social activities. These social relations outside of individual actors 'constitute the central form of combining resources in a society' (Heuser, 2005, p. 10, see also Bourdieu, 1986). Resources held within different societies vary, dependant both on who is in each society and how members interact. If the demographic composition of a society varies the resources at its disposal, it follows that social relations vary as a result of demographic change.

One element of the debate about cohesion relates to minority groups and the use of ethnicity or social status by which to define individuals or groups. Said's theoretical discussion of Orientalism explains how trysts and tensions may evolve between individuals or groups, as a result of perceived positional superiority within society (1978). Said argues that when an individual or group is unfamiliar, they may become a target of fascination or fear. Once this individual or groups is identified as different in some way from 'the norm', they become 'the other'. Differences, such as cultural or religious differences, become points of comparison. This is highly subjective, with 'the norm' and 'the other' being in relation to a community's existing or previous demographic, and considered by individuals themselves, with their own personal experiences. When there exists a wider feeling of 'them' and 'us', where different sections of a community resent, fear, or simply exist entirely separately from each other, cohesion fails. Beliefs held by individuals and groups may create barriers to cohesion which are difficult to overcome. If cohesion fails and there is no active intervention to improve the situation, the community may not be able to reintegrate successfully. Communities of individuals with similar characteristics may develop and exist in isolation from 'others'.

If the homogenisation of a community is damaging to its own progress, the success of a community relies on sustained interaction and co-operation between diverse members. 'It is hardly possible to overrate the value . . . of placing human beings in contact with persons dissimilar to themselves, and with modes of thought and action unlike those with which they are familiar . . . such communication has always been, and is peculiarly in the present age, one of the primary sources of progress' (Mill, 1848, p. 594). If one then considers interpersonal interaction as an indicator of progress, one may be able to explore forms of interaction within a community by which to investigate its development. Relating this to regeneration activity is a logical step—if we seek to improve local fortunes through physical redevelopment, what is the evidence to suggest that this influences community behaviours and social development? The next section of this chapter discusses the relevance of social capital to the regeneration agenda, considering how notions of social capital can be practically applied to measure the social effects of regeneration activity. The discussion progresses to highlight the importance of critical investigation within the most deprived communities.

USING NOTIONS OF SOCIAL CAPITAL TO EXPLORE THE SOCIAL EFFECTS OF REGENERATION ACTIVITY

If we accept that interaction and social behaviour are fundamental in allowing communities to thrive and progress, we must identify ways to measure and record these interactions by which to explore change. Theories of social capital offer means to make sense of and classify the ways in which different members of communities interact and explore how these relate to different social effects. Social capital is a complex and multifarious concept which places value on social order, behaviours and relationships. The combination of these normal patterns of behaviour and everyday activities combine to create shared community resources. 'Social capital is not the sum of linear social formulae; it is not a predictable or exact science. Society amasses social capital through combinations of individual actions 'scaling up' into social phenomena' (Hall, 2012, p. 39). If urban development influences social interactions through changing the composition of local communities, the interests and life experiences of residents as well the practices by which they live their lives, social capital will be influenced.

Social capital is an important concept within academic debate and government policy (Putnam, 2002; Harper, 2002; Mace et al., 2007; Department for Communities and Local Government, 2009; Hall, 2012). Ideas which the term encompasses align closely with contemporary policy narrative within the UK; moreover, these ideas seem to resonate with individuals' understanding of how communities work. At the heart of social capital is the idea that, generally speaking, the more tolerant

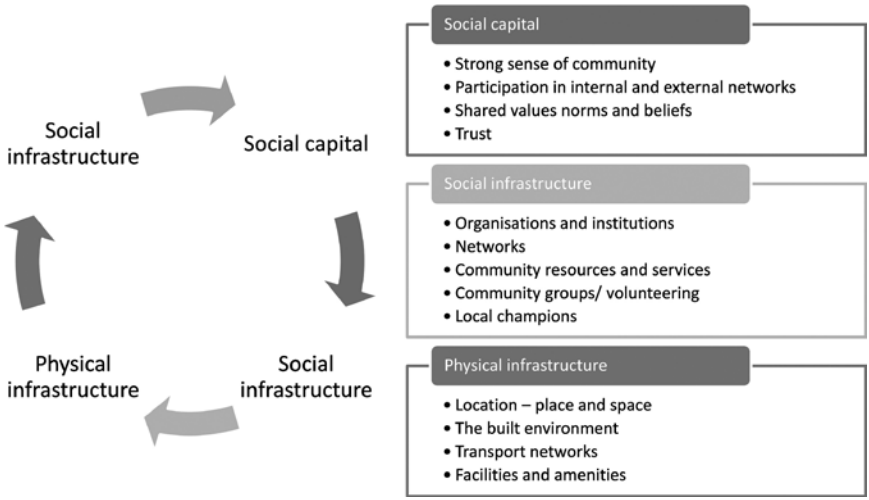

Figure 28.2. The theoretical cyclical relationship between physical infrastructure, social infrastructure and social capital.

Adapted from Simpson et al., 2001 and Simpson, 2005.

and co-operative the community dynamics, the better the results are for everyone in many different aspects. Social capital as a notion legitimises the understanding that different forms of relationship between different parts of communities have meaning and importance. Different forms of social capital are categorised as 'bonding', 'bridging' and 'linking' social capital, each form having different effects for individuals concerned. The close bonds which people form with family or friends are good for 'getting by' in life. Weaker, more cross-cutting ties bridge individuals and their businesses associates or acquaintances and are good for 'getting ahead'. People link with those in a hierarchy where there are different levels of power involved, and this form of interaction is useful for gaining support from institutions (see Harper and Kelly, 2003, p. 3).

These forms of capital are played out along different themes that help to form community relations; it is the multifarious combination of forms of interaction along different themes which shape individuals' or communities' social resource. The UK Office for National Statistics identifies five key themes which underpin social capital:

- Views about the local area (e.g., satisfaction with living in the area, problems in the area, fear of crime);
- Civic participation (e.g., propensity to vote, action on local and national issues);
- Social networks and support (e.g., contact with friends and relatives);
- Social participation (e.g., involvement in groups and voluntary activities); and
- Reciprocity and trust (e.g., trusting other people, trust in the courts or police) (Hall, 2010, pp. 2–3).

An individual's subjective views and practices around the five themes act to promote, sustain or inhibit their own forms of social capital. For example, were an individual to feel that there were problems in the local area (theme) and that they can rely on their community and public authorities for support to resolve these issues (forms of capital), then they may have good levels of social capital. However, were an individual to feel that lines of communication with local authorities are good (form of capital) but that they didn't trust the authority to be effective in their actions (theme), their levels of social capital may be compromised. This complexity of interrelated actions and meanings form the 'networks together with shared norms, values and understandings that facilitate co-operation within or among groups' (Coté et al. 2001, p. 41). It is essential then, to pay close regard to the behaviours and feelings of actors within a community in order to understand how it operates and how it is changing over time.

In processes of regeneration, physical changes to the urban built environment may influence social capital through changing the perceptions or practices of individuals. Introducing new development into established areas will necessarily change how previously developed sites are used, changing how people act around the sites and how people use the sites. This may create different opportunities for individuals to

interact—it may also limit individuals from acting in existing patterns. For example, a disused site may be used informally by residents for leisure activities such as walking their dogs. Whilst new development might offer different opportunities, such as shops or community facilities, removing the potential for the site to be used for dog walking necessarily influences the purpose of the site, its role in the community and the manner in which the community relates to it. It is equally important to consider how social capital is influenced by processes of regeneration as much as the final result. Experiences in dealing with the local authority through the planning system, for example, may alter an individual's perception of the local authority as a whole and may then influence how social capital exists for an individual—a good experience may improve trust and a feeling of influence in one's own local area, but a negative experience may disenfranchise the individual and create feelings of inefficacy and disempowerment. Networks may be disrupted, new networks may form and events may influence the ways in which communities relate to themselves and to other communities.

The social capital effects of regeneration have been touched upon in existing literature seeking to understand how processes of physical change influence local communities (Hibbett et al., 2001, Taylor, 2000, Kearns, 2003). Where the aims of brownfield regeneration extend beyond physical and economic returns on development, it is essential to explore whether and to what extent regeneration activity addresses its social ambitions. Whilst the language and policies of the regeneration agenda have evolved through successive governments, developmental and social pressures on UK built environments remain. Perhaps more than ever, the social ambitions of the coalition (Conservative and Liberal Democrat) align closely with notions of social capital, of seeking to build social trust, to increase political participation and sociability. Without a thorough and robust evidence base with which to inform policy formation, these ambitions cannot be effectively realised. It is then implicit on regeneration practitioners, academics and policymakers to then develop the evidence base for the social impacts of regeneration.

Emphasis remains on the priority to enhance struggling local communities through the National Brownfield Strategy (English Partnerships, 2003). As has been discussed earlier in this chapter, UK development policies intervene to stimulate the redevelopment of less economically buoyant areas. This conscious redirection of development activity underlines the importance of social equity within the UK regeneration context. The next subsection then considers the importance of investigating the social impacts of regeneration within the most deprived communities of the UK, highlighting the evidence for a relationship between brownfield land re-use and areas suffering from multiple deprivation.

The Importance of Investigating the Most Deprived Communities

Since the initial eruption of city-centre redevelopment in the early 1990s, more peripheral and more deprived areas have become the focus of brownfield redevelop-

ment activity (Hall, 2012). Larger, more attractive sites in more viable locations have mostly been 'used up', and developers have subsequently found sites further dispersed from city centres to use in new development opportunities. Where city centre regeneration generally led to the formation of new communities where there was not already a significant residential population, brownfield redevelopment in more peripheral areas typically takes place within existing local communities. The key difference here is the increased likelihood of social effects through developing in areas with more voluminous and dense resident populations; there is more likely to be an impact where there are more people present.

So recent brownfield redevelopment influences greater resident populations. It is intrinsically important to also recognise that recent activity also targets the more deprived communities. Market-led redevelopment seeks to profit from development activity, and so is preoccupied with the creation of profit rather than social objectives. Developers find sites at low cost to maximise profit, and these sites are typically found in less attractive locations. Of course, it is a balancing act identifying a site at the right price but also in an area that is attractive enough that people will be willing to buy new properties in the scheme. Sites often must be of sufficient size that redevelopment has the potential to alter the local environment; to constitute, for the purposes of a homebuyer investing in the area, an 'improvement' to the locality. What resident populations are then faced with are new developments which represent a change in their local area, seeking to provide for the demands of potential homebuyers rather than aiming to address existing local needs. One might consider that market development in this way exploits deprived communities by ignoring local need and using local sites simply to create private profit. One common counterargument to this view is that simply making use of a disused site and redeveloping within a deprived area comprises local investment which has the capacity to stimulate and attract further local investment, which will in turn benefit local residents. Whether such a 'trickle down' approach to regeneration benefits existing local residents is moot (Hall, 2012).

Returning to consider the social effects of regeneration activity, once more we see that deprived populations are most vulnerable. In terms of locally held social resources, the most deprived areas have higher historical prevalence of civil unrest. When one considers areas of the UK which have historically experienced social disorder and civil tension, these tend to be the most deprived communities (The Independent Online, 2001). Where one experiences such problems, one may expect to find poor community cohesion, low levels of local trust and little social capital. However, correlation does not infer causality; an area suffering from civil unrest does not necessarily lack social capital, nor does poor community cohesion necessarily cause civil unrest. Relating social capital to social effects such as deprivation or exclusion has been criticised for both containing too many different meanings to make one comprehensible argument and for lacking any robust evidence (Lees, 2008; Fine, 2001; Kearns, 2003). The 'sack of analytical potatoes' which forms discourse around social capital demands unambiguous definition of terminology for any piece

of research to have clarity and meaning; it is important then to be clear and precise when referring to different related social effects (Fine, 2001, p. 190).

When considering social capital, the definition used by many key organisations, including the OECD, is 'the norms and social relations embedded in the social structures of societies that enable people to co-ordinate action to achieve desired goals' (Grootaert, 1998; OECD, 2003; Hall, 2012). This definition of social capital is important when considering the most deprived, as it presents social capital as a mechanism for creating opportunities for development and achievement when other resources may be lacking. Earlier in this chapter the theoretical relationship between physical regeneration and social capital effects were outlined. With the focus of regeneration activity increasingly taking place within more deprived, more vulnerable communities, it is then imperative to investigate the social capital effects of brownfield regeneration. To assume that development activity promotes social capital, through a hypothetical positive relationship between economic improvement and social development, is insufficient. The following section presents key findings from research in Manchester, UK, which seeks to measure the social capital effects of brownfield regeneration in deprived communities. The final section of this chapter reflects on these case study findings in the context of discourses of both social capital and brownfield regeneration.

CASE STUDY: MEASURING THE SOCIAL CAPITAL EFFECT OF BROWNFIELD REGENERATION IN DEPRIVED URBAN AREAS OF MANCHESTER, UK

Manchester, a city in the northwest of England, grew significantly during and was one key focus of the Industrial Revolution. Beyond England, Manchester became an international centre for a number of innovative industries, of which textiles was the clear forerunner. Unlimited by planning constraints, the city expanded in a mosaic of industrial use and residential properties. Since this time, economic restructuring led to the disuse of industrial units. The existing fabric of the urban built environment became, in parts, unfit for purpose. By the end of the 1980s, the city centre had very low numbers of residents, with vast swathes of previously developed land left unused. These sites were considered unattractive to developers; there was no consumer demand for residential properties in the city, and the sites posed problems with redevelopment associated with their previous uses. A conscious policy effort to target new development in these declining areas corresponded with a tide-change in fashion. All at once, in the early 1990s, modern living became defined by city-centre living. Giant industrial structures, such as former mills and factories, were re-imagined as residential properties, divided into apartments and sold on the wave of this urban renaissance. City-centre living became edgy, attractive and decidedly middle class. Developers and individuals became willing to invest in the city, and thousands of new apartment buildings sprung up to exploit new opportunities.

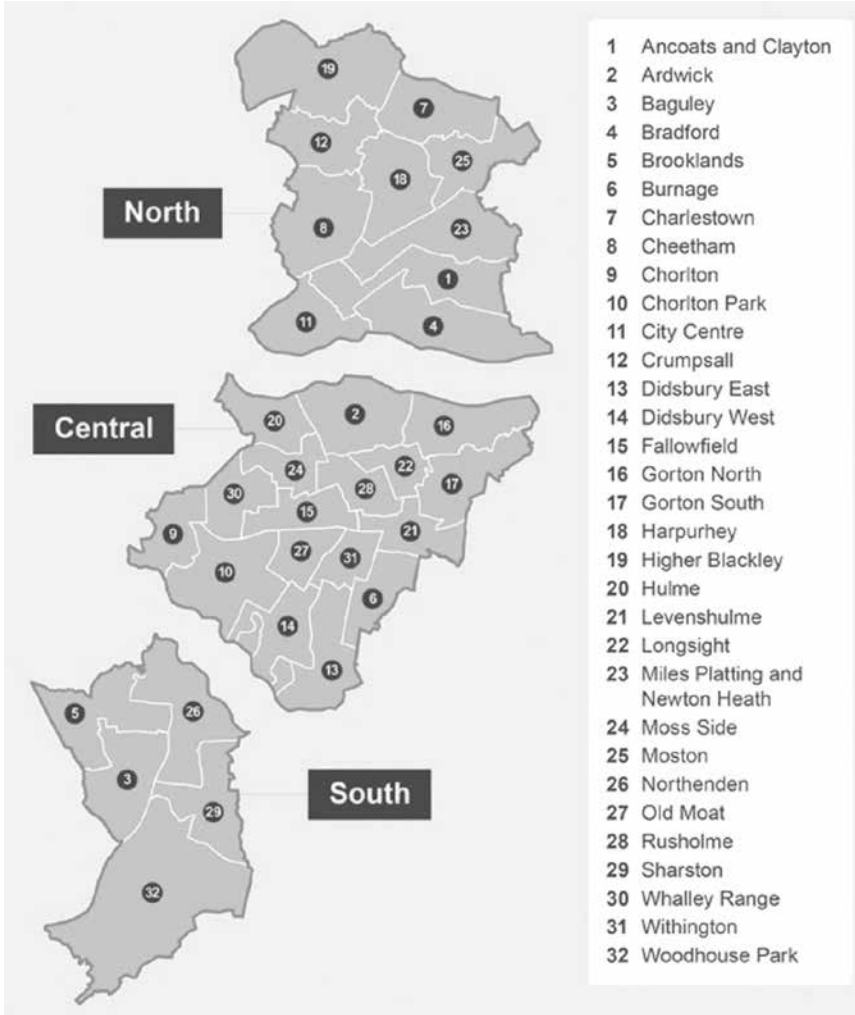

Figure 28.3. Map of local wards in Manchester.

Source: Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Greater Manchester, 2012.

Through encouraging, supporting and facilitating urban growth, Manchester City Council focussed on improving run-down parts of the city throughout the 1990s. As yet, no formal evaluation of regeneration efforts has been produced by the city council, whose far-reaching aims sought to improve local areas' economic and social well-being. Certainly, a lot of public and private finance was invested within deprived urban communities. Many of the organisations who funded redevelopment have, themselves, been subject to significant change since these programmes started—The

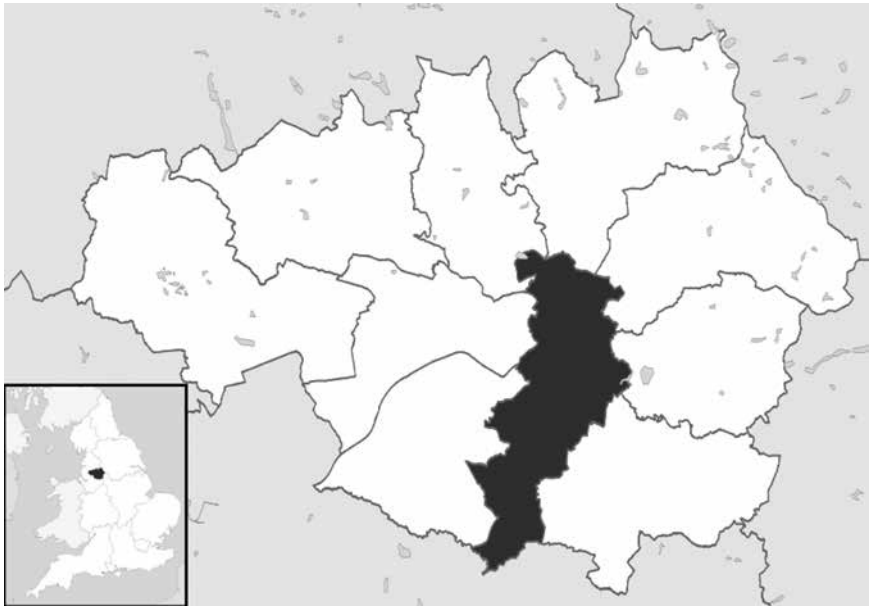

Figure 28.4. Map showing the location of Manchester within Greater Manchester and England.
Source: Wikipedia, 2012.

Northwest Regional Development Agency no longer exists, English Partnerships has become the Homes and Communities Agency, with significant alterations to its remit, and the Labour Government has been replaced by a Coalition Government between the Conservative and Liberal Democrat parties. Severe cuts across the public sector since the economic recession have limited the capacity of many organisations to conduct research or evaluate historic programmes, and so it is unclear what form any summative evaluation exploring the effects of regeneration activity might take.

Seeking to enhance the evidence base for a relationship between social change and regeneration activity, research has been developing techniques to measure the social capital effects of brownfield regeneration in deprived urban areas (Hall, 2012). Having created a neighbourhood-specific development typology, four case studies across Manchester have been investigated. The case studies, derived and amended from Hall (2012), represent the four key forms of development completed in different types of deprived neighbourhoods as derived from Manchester City Council development completion records between 2001 and 2005.

- *Replicator owners and renters*—Chorlton Park. Such developments are typically private development, though there is some degree of social housing investment. These are medium-sized schemes, providing accommodation for households who move from and move to areas that are equally or more deprived. The

properties serve to replicate the status quo in terms of the sections of society which they target.

- *Stepping stone owners*—Cheetwood. These developments are medium-sized and are generally private development. Those moving into these estates come from more deprived backgrounds, and those who move out go to less deprived areas. In this way, these properties serve for private homeowners moving up the housing ladder.
- *Gentrifying settler owners*—Hulme. These extensive regeneration schemes are large and predominantly private. New residents are attracted from less deprived areas, and existing residents move to more deprived areas. Though it may not be deliberate, such housing schemes may have the effect of displacing deprived existing communities to provide for the less deprived.
- *First-time, transient owners*—Fallowfield/Whalley Range. These developments are medium to large in scale and represent first-time purchases for homeowners. Residents typically come from less deprived areas, such as the parental home, and those who move out typically go to less deprived areas. The transient nature of these neighbourhoods reflects the homeowner aspirations of residents as they move further in their careers.

Each case study, by virtue of the identification process, falls within the 10 percent most deprived lower super output areas (LSOA)[1] nationally as of 2001. The development typology is influenced by an existing typology of deprived areas, progressing this to consider brownfield redevelopment activity on the ground (Robson et al., 2008). Considering the four neighbourhood-specific development typologies, most development occurring in deprived neighbourhoods ten years ago in Manchester was for private housing. Whilst Registered Social Landlord (RSL) provision was created in all types of deprived neighbourhoods, a significantly greater proportion was created in isolated areas, defining the replicator category of development as for both owners and renters.

The four case studies were investigated through in-depth, semi-structured interviews and focus groups with key stakeholders and local residents. Focussing on social capital, questions were formed relating to the five themes of social capital and using the Office for National Statistics' Social Capital Question Bank. Having collated data from the four studies, key discussion areas have emerged through analysis. The following three subsections discuss four key themes:

- Lower-level administrative boundaries may not be appropriate geographies for investigating local social change, or indeed for policy formation;
- The case studies generally support theory, insofar as differently structured communities appear differently resourced to improve their success;
- There are aspects of the case studies which demonstrate the role of social capital in perpetuating disadvantage in communities, raising the need to consider what may be 'acceptable' forms of social capital; and

- The perceptions of community structures and the reality of an area's liveability may not align. Negative impressions of an area may form a barrier to residents developing social capital with members of other communities.

IMPACT OF USING LOWER-LEVEL GEOGRAPHIES AND NEIGHBOURHOOD CLASSIFICATIONS TO INVESTIGATE THE LOCAL EFFECTS OF REGENERATION

With the exception of the Hulme area, the case studies have highlighted problems with the use of administrative ward boundaries by which to spatially group local communities. The Cheetwood area in Cheetham is considered colloquially by the local authority to be part of the Northern areas of Cheetham, rather than part of the LSOA in which it falls; as such the site is considered an isolated rather than escalator area when the local authority forms policy and develops intervention measures (Hall, 2012). The Chorlton Park boundary includes two almost entirely separate communities, which by virtue of administrative boundaries are considered as one community when statistics are collated to indicate local characteristics. The Whalley Range/Fallowfield case study provides an example of the need to review and reconsider administrative boundaries to reflect the development of local areas and the function of local communities; whilst the site was considered part of the Fallowfield area a decade ago, based on the role of the site within the Whalley Range locality, the administrative boundaries have been revised.

It is evident that existing lower-level boundaries may not reflect the 'true' nature of local communities, and this raises concerns as to the use of LSOA-derived statistics for inferring local change over time. Disparate communities, such as in Chorlton Park, may operate in close proximity without interaction; figures then may be skewed and local policies may be insensitive to these idiosyncrasies. Certainly, it appears that the use of neighbourhood typologies to infer local characteristics may be too simplistic and generalised. Should policies be formed from statistics based on these lower-level geographies there is a significant risk that actions would be inappropriate to communities 'on the ground'. The model of close community working and engaging in developing local plans as demonstrated by the Big Life Group[2] appears to be successful in delivering programmes of activity which are suitable for local residents. There may be an argument for devolving certain powers and responsibilities over to third sector groups[3] with closer working relations in deprived communities.

HOW CASE STUDY FINDINGS ALIGN WITH THEORIES OF SOCIAL CAPITAL

Relationships between levels of social capital and neighbourhood-specific typologies support the notion that different forms of social interaction relate to and influence

different individual and community fortunes. Case study characteristics reflect the diverse nature of formal and informal support in these areas, as well as different forms of engagement, different feelings of local influence, and different perceptions of the local community and different norms of reciprocal behaviour. Yet the Whalley Range case study appears to have little in the way of formal support arrangements, and the area remains attractive to first-time buyers, who may lack local roots and be vulnerable to social isolation. This suggests that perhaps informal social support requires more investigation to explore how engagement outside of more formal arenas influences local success. It is important to consider how more mundane and daily interactions influence the liveability of the area—residents may feel more vulnerable in a local area for no reason other than a perception that new and unfamiliar people have moved into an area and they do not fit into an individual's experience and understanding of how the local community operates. For example, one resident in Whalley Range said she feels more vulnerable on the streets now than ten years ago—not because there are more people on the street, but because as her own young family had moved away she no longer felt like she knew enough about the people in her local area (Hall, 2012). Diminishing local social networks then may influence one's own perception of security in a local community.

Figure 28.5. The Cheetwood community centre, located in the heart of a newly regenerated residential neighbourhood.

Source: author's own.

Reflecting discourses on the potential negative aspects of social capital, the case studies have displayed a perception that antisocial communities also significantly benefit from their own close, locally formed relationships and ties. Social supports and a feeling that other members of a criminal community are 'looking out for' and 'protecting' each other may negatively influence the local community, despite the area being rich in social capital. The close ties between such individuals enable criminal activity to continue through providing actors with a sense of security in the local area. The Cheetwood Community Centre (see figure 28.5) spent its first re-opened year involving local police officers to disrupt the social practices of criminal groups, to make such criminal behaviour feel less 'safe' and acceptable in the local area. In this respect, positive social effects have been felt by some members of the community at the detriment of social capital held by other members. It is important in ongoing analysis, then, to consider the role of subjectivity in implementing development and support visions. The role of local context in planning action for 'the greater good' may be significant—in order to allow 'acceptable' forms of social capital to develop, interventions may be required to disrupt 'unacceptable' forms of social capital. The judgement calls which decide what is considered acceptable or not may be best determined at the neighbourhood level where a thorough understanding of the local tensions at play exists.

PERCEPTIONS VS. REALITY—HOW RESIDENTS FEEL ABOUT COMMUNITY STRUCTURES COMPARED TO THE REPUTATION OF THEIR LOCAL AREA

There is a prominent understanding across the case studies that perceptions about local areas do not reflect the true nature of activity in these communities. The regeneration activity which forms the nuclei of these case studies is considered fairly recent; locally ingrained perceptions may take much longer to form and develop in individual and collective conscious. Moreover, such perceptions may restrict the successful rehabilitation of declining areas through causing people to avoid certain areas. In the Cheetwood case, residents from adjoining areas have 'always avoided the estate' as they felt it to be unsafe and inhospitable (Hall, 2012). Without intervention to link and integrate separate communities, parallel lives will continue to develop and cultures of fear and distrust will become more deeply entrenched in the local psyche. Despite recent physical regeneration activity, local communities are only enabled to develop through appropriate social regeneration efforts.

Comparing the Chorlton Park and Cheetham case studies, their social activity contexts appear to indicate a positive relationship between social regeneration efforts and neighbourhood-specific development typologies. There are significant cross-institutional and local social support networks operating in Cheetwood and wider Cheetham, alongside regeneration activity, to ensure that local residents have access to opportunities to develop as individuals and within the community. The

Cheetham case indicates that people living in these developments are improving their fortunes whilst living in the area, so one might conclude that local support is facilitating personal development. The Chorlton Park case indicates minimal social support networks operating to support local residents, with embryonic attempts to develop the local community working in isolation. People living in this area appear not to be improving their fortunes, with residents staying trapped in cycles of deprivation. Perhaps, then, it is not the form of physical development which determines the ongoing development of local communities; perhaps it is the role of social development alongside regeneration which allows individuals to access opportunities to improve their lives.

Guinness Northern Counties, a private RSL, largely fund the activities of the community centre in Cheetwood in addition to managing a significant volume of local properties. This community-oriented approach helps to secure the role of the RSL within the local area and is said to improve the maintenance of their properties (Hall, 2012). Unlike development in Chorlton Park, the approach to regeneration in Cheetwood has involved a combination of physical improvement and social support—perhaps this dual approach is the key to facilitating development within the local community. In terms of the contrast between perception and reality, the two local areas are again diverse. Stakeholders and residents in Chorlton Park do not feel that the area is getting better; a negative impression of local fortune persists which is borne out in local statistics (Hall, 2012). In Cheetwood, despite ongoing negative perceptions of the local area, there is a cautious excitement in the local community that the area is improving. Local people feel that they being helped out of unsatisfactory situations and that their lives are slowly getting better (Hall, 2012). Whilst perceptions may take a long time to change, it is critical in ongoing analysis to continue to explore the role of social support alongside physical regeneration in changing local communities' realities.

CASE STUDY REFLECTION

Early indications from research findings suggest that the form and tenure of development may influence the degree to which local communities are able to develop social capital; however, it should be emphasised that this appears to be only half of the story. One key finding of note across all case studies is that there appears to be a positive relationship between a collaborative approach to developing local areas socially alongside physical regeneration and a local community's ability to improve its own fortune. Where social development has occurred alongside physical development, local residents have been able to raise their aspirations and personal attainment through the development of social capital. For example, the community centre in Cheetwood has enabled local residents to request affordable trade-specific training to be offered to the community, which has allowed individuals to access new employment opportunities (Hall, 2012). Other themes emerging from early

findings have been discussed, which are the subject of in-depth analysis in Hall (2012):

- Lower-level administrative boundaries may not be appropriate geographies for investigating local social change, or indeed for policy formation;
- The case studies generally support theory, insofar as differently structured communities appear differently resourced to improve their success;
- There are aspects of the case studies which demonstrate the role of social capital in perpetuating disadvantage in communities, raising the need to consider what may be 'acceptable' forms of social capital; and
- The perceptions of community structures and the reality of an area's liveability may not align. Negative impressions of an area may form a barrier to residents developing social capital with members of other communities.

CONCLUSION

This chapter has provided an introduction to brownfield regeneration in the UK, discussing the industrial heritage of a number of large English cities and the legacy this has been left across many urban built environments. The processes of deindustrialisation across the UK have created a prevalence of previously developed sites which would be appropriate for reuse, though in some cases these sites have been left underdeveloped. Sequential preference for developing more central and more attractive brownfield sites first has influenced the development potential of sites within more peripheral and deprived areas. Economic and residential pressures on developable land, in combination with strict application of greenbelt policies, ultimately directed development activity towards deprived localities with available sites. Some ten to fifteen years after English cities first experienced the rush of urban renaissance, deprived localities saw significant levels of investment seeking to exploit previously developed sites.

There is a spatial dimension to patterns of land re-use and of deprivation. More deprived localities are found in the Northern cities of England, and more brownfield sites remain with latent development potential in these Northern cities than elsewhere in the country. Regeneration initiatives aimed to improve the economic and social well-being of these local areas, often assuming a positive linear relationship between capital investment and social benefits. The scope and remit of those organisations who were involved with redevelopment at the time have changed; the recession, in addition to policy evolution through successive governments, has created a situation where it is difficult to pinpoint those accountable to these regenerated communities. Summative efforts to evaluate the impacts of development within local communities are lacking, despite the logical theoretical relationship which identifies that altering an urban environment is likely to engender social effects. It is established through existing research that social capital has the capacity to support communities as a shared resource, when other forms of resource may be lacking.

That development efforts are targeted within deprived local communities with no effort to evaluate the social capital effects this might have is neglectful—it is simply insufficient to assume that intervention necessarily has positive results. It is therefore essential that further research takes place to understand the mid- to long-term social impacts of regeneration in these deprived communities; have physical regeneration programmes helped deprived individuals and groups to thrive, or have such schemes ignored the social needs of existing populations in favour of exploiting the financial capacity of new incomers?

Ongoing research is measuring the social capital effects of brownfield regeneration in different types of deprived communities across Manchester, UK, a city with high levels of deprivation and remaining volumes of brownfield stock. This research is adding important evidence to support incremental understanding of the effects that physical regeneration may engender within local populations. One key finding from this research is that lower-level administrative boundaries currently used in England by which to measure demographic and economic change may not be appropriate geographies to investigate social change; the formation of communities 'on the ground' is more complex and fluid than is currently considered within regeneration policy (Hall, 2012). In order to adequately consider the impacts of development, one must consider not simply the spatial distribution of communities but the behaviours, practices and habits which form social life. Differently structured communities appear to be differently resourced to improve their own well-being and success (Hall, 2012). This aligns with theories of social capital, and places increased value on the role of community structures in enabling communities to thrive. However, it is also important to note that social capital, through replicating behaviours and practices within existing structures, also has the potential to sustain and perpetuate disadvantage within communities. It may be useful to conduct further research into how communities relate to different forms of structures, and how they determine whether social activities are acceptable or not within a local context.

The final key finding which was discussed was the relationship between perceptions of a community and that community's ability to 'turn itself around'. Negative views of local areas were consistently reported, as part of interview data, to significantly limit opportunities for local social development. Despite physical and social investment in local areas, residents felt that 'outsiders' perceptions of the local area form a key barrier to allowing local people to thrive and succeed in their own lives. Negative connotations associated with local areas prevent different communities from interacting, and so these perceptions limit the potential for different forms of social capital to be formed with people outside of one's own immediate community.

In conclusion, social capital and social behaviour are of significant importance to the ongoing development of a local area, particularly where resources are scarce. Physical development within deprived communities in England has largely gone on unchecked, with little effort made to evaluate social effects. To exploit development opportunities within the most vulnerable local areas and not to consider the mid- to long- term impacts this might have is negligent; communities are built through

social interaction, not simply through creating new spaces for living. More than bricks and mortar, it is implicit on regeneration research in the UK that further investigation is conducted to understand how to build up and support our most vulnerable communities.

NOTES

1. Lower super output areas, or LSOAs, are geographical areas used to report small area statistics in England and Wales. The mean population of an LSOA is 1,500, with the minimum 1,000. LSOAs allow statistics to be reported for relatively small populations, which (with some work and contextual understanding) may be related to particular neighbourhoods.

2. The Big Life Group is one of the largest social businesses in England, operating five separate social businesses and three charities. Through Big Life Centres, the organisation runs health and community resource centres in neighbourhoods across Greater Manchester. Hall (2012) explores social change in four case study neighbourhoods, and observes that Big Life Centres operating alongside physical regeneration have helped to create social and economic benefits for local communities through establishing and maintaining effective support networks and building social capital.

3. Third sector groups are organisations such as charities which function in parallel to the market towards social objectives in not-for-profit operations. The coalition Conservative and Liberal Democrat government in England, elected in 2010, have promoted through the Localism Bill the notion that third sector and community groups can take control over the running of local authority services (DCLG, 2011). This has been the subject of much debate, with some fears that this will devolve responsibility away from the state and increase inequities between local areas (Hall, 2012).

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29

Disasters as Hyper-Marginalization

Social Abandonment in the Lower Ninth Ward of New Orleans

Daina Cheyenne Harvey

Hurricane Katrina and the federal levee failures in New Orleans have resulted in numerous calls to recast the literature on disaster. According to these scholars Katrina has necessitated a paradigm shift in how we understand disasters and the larger relationship between disasters and society (Brunsma, Overfelt, and Picou, 2007; Clarke, 2007; Picou, 2009). While this call has resulted in an outpouring of work and extended disaster research into other major fields of study, the role of disasters as a tool of urban marginalization remains underemphasized. Despite some recognition that the aftermath of Katrina was designed to marginalize particular portions of the population (Klein, 2007), there has been little analysis of how this marginalization has been experienced (for a rare exception see Adams et al., 2009; Chamlee-Wright and Storr, 2010).

In this chapter I argue that we are witnessing a new form of urban marginalization. It is not the case that older forms of marginalization, or newer ones, such as Wacquant's advanced marginalization, have become obsolete. Unfortunately those marginalizing projects are still with us. Rather, what I argue is that disasters are increasingly being used to further the process of urban marginalization. I call this form of urban marginalization hyper-marginalization. It is accomplished by various kinds of *secondary violences* that punish and abuse the marginalized. These violences have, at least in New Orleans, in part, consisted of a massive bureaucracy to deal with claims of damage and loss—which continually loses paperwork or requires that people begin the process anew every few months, a racially discriminatory

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government-funded rebuilding and grant program that remunerated homeowners far below what it would cost to rebuild their homes, policies that did not allow residents in the Lower Ninth Ward to begin rebuilding for almost a year after Katrina, environmental racism, delays in restoring or rebuilding infrastructure, and the failure to return vital public services, such as police or health, to the community.

The secondary violences, which have been visited upon members of the post-Katrina population, have been, in part, both a putative solution to pre-existing urban problems and a retaliatory measure for not acquiescing to the elite plan of "Katrina Cleansing" (Sanyika, 2009: 94). They represent a new marginalizing strategy, using social disruption in the aftermath of a disaster as a means of facilitating social deprivation and exclusion. The result has been a level of social abandonment previously unthinkable to even those who have long experienced marginalization in the city. Furthermore, residents' understanding of their marginalization, which has been expressed mainly in contractarian terms (Chamlee-Wright and Storr, 2010), has been acutely recognized for what it is, an abrogation of the social contract.

The plan for this chapter is to briefly introduce the reader to the concept of hyper-marginalization by examining several outcomes of the secondary violences associated with Hurricane Katrina in the Lower Ninth Ward of New Orleans. In the following section I discuss the literature on disasters and marginalized populations, noting that disaster studies have only recently begun to connect the two to the marginalizing process. In the second section I note the long history of marginalization in the Lower Ninth Ward. Section three explores the hyper-marginalization of the Lower Ninth Ward after Katrina and the federal levee disaster. There I describe how the secondary violences, which have marked the period since Katrina, have led to hyper-marginalization and note several outcomes experienced by residents of the Lower Ninth Ward. In the final section I make some concluding remarks.

DISASTERS AS URBAN MARGINALIZATION

In the last few decades we have become increasingly aware that the effects of disasters are not random. Social vulnerability studies have explicitly demonstrated that disasters worsen inequality and stratification (Morrow, 1999; Barnshaw, 2005; Barnshaw and Trainor, 2007). Laska and Morrow (2006) note that socioeconomic conditions often effect not only a community's ability to prepare for a disaster but also recovery and resiliency. Within New Orleans, a number of studies have reached the same conclusion, namely that minorities, the elderly, and the poor suffered disproportionately during Katrina and have since been the least likely to return to New Orleans (Laska and Morrow, 2006; Logan, 2007; Finch et al., 2010). And yet while social vulnerability studies frame disasters in terms of marginality, urban sociology and disaster studies have long ignored that disaster often speeds up the effects of previous marginalizing processes (Freudenburg et al., 2009a).

Furthermore, Peacock et al. (1997) and Comerio (1998) show that recovery after disasters is marked by both historical and social factors unrelated to the destruction itself. And as Finch et al. (2010) note, recovery in New Orleans, and for future disasters, seems less about social vulnerability and more about policies that facilitate the return and recovery of some groups over others (see also Green, Bates, and Smyth, 2007). It is well known that disasters further marginalize already marginalized communities, but exactly how and in what ways the marginalization is accomplished, or perhaps more importantly, what the process does to the community, remains unclear. I argue that in New Orleans, and elsewhere, disasters have become a form of urban triage, an excuse and exercise to punish and further exclude the marginalized. This argument assumes, following Freudenburg et al. 2008, 2009a, that the damage and destruction caused by disasters has historically been *naturalized* rather than correctly understood as an outcome of economic and urban policies that favor the wealthy and middle class over the poor and whites over blacks and Hispanics. In this section I look at three ways in which disasters, specifically Katrina, have become a tool of urban marginalization.

Disasters are used as an excuse to devalorize social life in marginalized neighborhoods. The state sector and private sector desertification that Wacquant (2008) describes as a function of the ghetto, the way in which the ghetto is made to be a dangerous place, applies also to post-disaster ghettos. In the aftermath of Katrina, a lassiez-faire policy, largely mimicking urban policy over the last quarter century, guided disaster response in most marginalized communities. It is still the official policy in the Lower Ninth. This is part of the planned shrinkage of marginalized spaces. In this way no one wants to enter the space or become part of the community and thus the state can refuse to extend basic services, such as protection or infrastructure, on the basis that too few residents have returned or that resources are needed throughout the city, while the private-sector can use the state's absence as an excuse to not return. On the surface then, the decomposition of place seems the fault of its residents rather than the institutions that other communities take for granted. While some residents place blame where appropriate, many blame those who have not returned or rebuilt or who have failed to become involved in the grass roots protesting of neighborhood conditions. Thus this devalorization not only marginalizes residents of the community from those neighborhoods that "have returned," but it also marginalizes them from one another.

A second way in which disasters are used as a form of urban marginalization is in the redistribution of money away from social welfare projects towards middle-class and upper-class projects. Davis (1998), for example, notes that above all else disasters can be recast as class struggle. In his examination of recovery in the aftermath of the Northridge earthquake, he shows how funding for rebuilding was skewed towards commercial and upscale areas and that neoliberal policies often dictated cutbacks or offsets in services or programs for the marginalized to cover disaster relief. Ultimately, social welfare projects are derailed altogether. This disinvestment

in marginalized communities is often overlooked in the aftermath of disaster. In the Lower Ninth Ward, for example, bond issues that had been passed years earlier to build community projects were put on hold in the aftermath of Katrina. Not only have the projects been permanently stalled, but the bond money was illegally reallocated to fund other projects elsewhere in the city. Likewise, street repairs and other infrastructural issues have been delayed there, but addressed elsewhere in the city. This redistributive strategy exacerbates quality of life differences in middle-class and lower-class spaces and reifies the distinction between good and bad places.

The final way in which disasters do the job of urban marginalization is displacement. Much like the destruction of black and Hispanic communities in the 1940s-1960s by housing, freeway, and other "public" projects, disasters break up communities. In New Orleans this was accomplished by the refusal of the government (at all levels) to rebuild particular communities, but also to disassemble public housing. While many could return to New Orleans, housing assistance programs have done very little to help renters, and many neighborhoods have moratoriums on the building of multi-dwelling units. Rent in New Orleans has increased almost 50 percent since Katrina (Kromm and Sturgis, 2006), and the number of mid-priced rental units ($300 to $600/month) went from 66,300 in 2004 to 19,300 five years later (American Housing Survey, 2009). Even worse, the number of worst-case renter households, those that pay over 50 percent of their household income to rent, increased by almost 25 percent (American Housing Survey, 2009). But displacement was also accomplished by simply removing people from the city. The most marginalized were put on planes and buses and taken out of the city with no means to return.[1] This strategy has weakened social capital and destroyed networks by breaking up families and communities, further increasing their marginality.

Popular sentiment after Katrina was that disasters cannot be predicted. The underlying assumption behind such as a statement is that hurricanes are agent-less. In the following section I briefly look at the history of New Orleans, and in particular the Lower Ninth Ward, to demonstrate the agents of marginalization and disaster.

MARGINALIZATION AND THE LOWER NINTH WARD

The venerable historian of black history, Kent Germany, calls the Lower Ninth Ward the most socially marginalized place in the US (2007). It began as a mix of plantation space and swampland and was later developed into a stockyard and industrial space, but for the most part it was simply forgotten. It was settled by poor blacks and immigrant families who were looking for cheap farmland. Families who settled there were forced to endure flooding and epic bouts of disease. In the 1920s the construction of the Industrial Canal bisected the Ninth Ward into upper and lower halves beginning, in the minds of many current residents, the economic and civic separation of the neighborhood from the rest of the city.

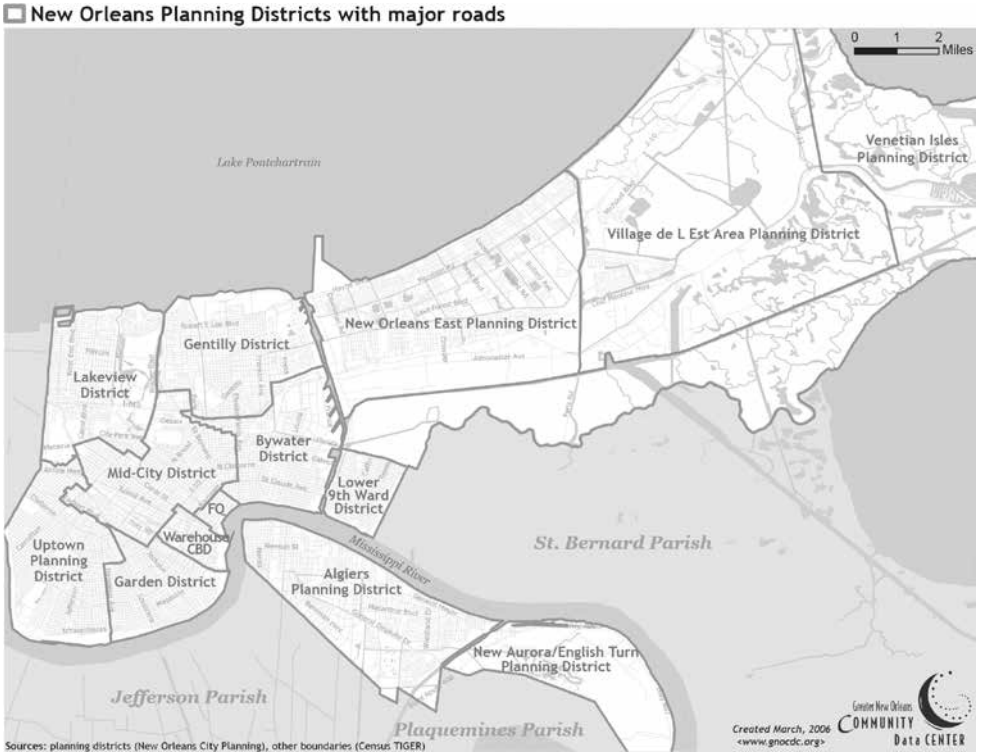

Figure 29.1. Map of New Orleans Planning Districts.
Greater New Orleans Community Data Center (March 2006). New Orleans Planning Districts with major roads.
Retrieved from https://gnocdc.s3.amazonaws.com/maps/PDFs/NOLA_planning_districts.pdf.

But residents also felt that there was the possibility of great environmental harm that would come from maintaining the canal, and that the community was being put at greater risk for catastrophic flooding by having the canal as a border. Their fears were realized during Hurricane Betsy in 1965. Betsy obliterated the levee and flooded the entire Lower Ninth Ward. This disaster resulted, according to some in the neighborhood, in an economic disaster—White Flight.[2] Whites who were able moved to what they viewed as safer neighborhoods. Businesses followed those whites to the suburbs and neighboring parishes. For some who still live in the Lower Ninth the neighborhood was never the same after Betsy and White Flight.

Some residents, however, note that Betsy was not that bad and certainly not as bad as Katrina. As Freudenburg et al. (2008, 2009a, 2009b) and others (Shaffer et al., 2009) note, the main difference between 1965 and 2005 was the Mississippi River Gulf Outlet (MRGO). Residents of the Lower Ninth fought the construction of the MRGO, claiming, correctly, that as an inlet it would allow saltwater in and kill the wetlands, thus destroying a vital line of defense against wind and storm surge that occur during hurricanes. Their fears were unfortunately proved correct during Katrina. MRGO proved to be the costliest example of social exclusion in New Orleans. Despite decades of asking for its closure and only receiving environmental degradation for its existence, the Lower Ninth Ward was completely inundated by water, up to eighteen feet in some places, as the MRGO funneled water into and eventually over the canal wall.

Likewise, because of the water and levee projects, other infrastructural needs were rarely addressed. In part this neglect was the result of conscious decisions in the 1960s not to extend infrastructure developments to black neighborhoods in New Orleans for fear of taxpayer revolt. This produced a situation where 86 percent of roads in the Lower Ninth Ward lacked adequate paving and drainage before Katrina (Germany, 2007). And as Germany notes, housing has always been cited as the number-one social problem in New Orleans; in 1960 close to 30 percent of the city's houses were in a state of disrepair (2007). Estimates of blighted homes in the Lower Ninth Ward before Katrina run from 40 percent to 60 percent. As Khan (2009) explains, and as many residents echo, Katrina was not as responsible for the problems of the Lower Ninth as were the decades of policies that created and then perpetuated social marginalization and environmental racism. These decades represent a prelude to Katrina (Germany, 2007).

HYPER-MARGINALIZATION AND THE LOWER NINTH WARD

The destruction caused in the wake of Hurricane Katrina furthered the suffering and marginalization of residents of the Lower Ninth Ward. While the Lower Ninth was always both spatially and socially ostracized from the rest of the city, its stigmatization had always been a source of pride for many. Residents were also proud that the neighborhood lacked public housing and that it had one of the highest home

ownership rates for a black community in the US. It was perceived as a poor but working-class neighborhood; a mixed community, with doctors and lawyers and oil rig workers and teachers, but also drug dealers and gang members. Residents talk of its roller coaster history, the 1970s and early 1980s were good, the late 1980s and 1990s really bad, but by 2000 the neighborhood was coming back. With less than a third of its pre-Katrina population (the actual percentage of *returned* residents remains unknown), the majority of its residents remain internally displaced persons. Those who have returned have had to face the daunting task of rebuilding one of the city's most historically marginalized neighborhoods and have had to do so without help from the city, state or federal government.

The Bring New Orleans Back Commission's original plan for the Lower Ninth Ward was green space. Residents, both those who had returned and those who remained displaced, were unanimously vocal in that they would not allow the city to "finish the job Katrina began." This "push out" (Chamlee-Wright and Storr, 2010) narrative became so popular that it influenced rebuilding and resettlement patterns. Make it Right (Brad Pitt's project), for example, selected its location at precisely the spot where the Industrial Canal wall was breached to show others that if you can rebuild there, you can rebuild anywhere. Residents, fearful of Donald Trump–style developers, planned to resettle haphazardly. Early plans were to have the first returnees each rebuild on different blocks so as to discourage the wholesale buying of blocks. Whether the jack-o'lantern rebuilding has been (non)fortuitous and/or planned remains questionable. This push-out narrative is also responsible for the belief that not only was the destruction caused by Katrina intentional, but that recovery efforts have been purposely skewed to prevent residents from returning, and perhaps more importantly, to punish those who have returned. It has become difficult to deny the latter.

As of this writing, six years after Katrina and the federal levee failures, the Lower Ninth Ward lacks a grocery store, a fire station, a police sub-station, a drug store, a high school, or a community center. There are still homes in need of gutting; refrigerators with their pre-Katrina contents sit idle in dilapidated homes. It is the most blighted neighborhood in the country.

Much of this scene is naturalized by visitors. Finch et al. (2010), for example, find that the geographic pattern of recovery in New Orleans can be predicted by flood inundation maps.[3] Other attempts to interpret the pace of recovery hint at racism or blame the victims for their ineptitude in mishandling aid. But recovery in the Lower Ninth is not natural, nor is it what should have been expected. The recovery pattern there is due to what I call secondary violences.

Although no one denies that Hurricane Katrina and the flooding of New Orleans was one of the worst disasters in U.S. history, the aftermath has been far more disastrous for some. Vividly explained by others (Flaghtery, 2010; Rutledge, 2010), the road to recovery has been permanently blocked for many. While some have referred to the obstacles and incidents that prolong the disaster experience as secondary traumas (Gill, 2007) or secondary disasters (Erickson, 1976), I use the term *secondary*

Figure 29.2. An example of urban blight in the Lower Ninth Ward (five-and-one-half years after Hurricane Katrina and the federal levee failures).
Photo by author.

violences to underscore the agency and intentionality of the actions. These secondary violences are the result of policy choices. The destruction of urban communities and the dislocation that residents, both current and former, have been forced to endure needs to be placed in the larger context of violent, criminal action. Likewise, the tools used by those who have perpetuated these secondary violences will undoubtedly be used again to marginalize communities after a disaster and hence should be understood for what they are.

Most of these secondary violences have been well documented. In the immediate aftermath of Katrina, public schools, hospitals, and clinics were shuttered, while almost all public housing was destroyed. Likewise, an immediate racialization of place occurred afterward, with white spaces marked for rebuilding and black spaces marked for other uses. Other violences, however, have remained out of the public eye.

Despite being aware for decades of fair housing and anti-discriminatory policies, race continues to mark resiliency issues. While levees and flood protection programs have been improved in white areas, low-lying black areas like the Lower Ninth Ward have received little to no attention. Likewise, transportation options have been severely diminished in marginalized communities, with NORTA (New Orleans Rail and Transit Authority) cutting almost half of all routes and half of the number of buses in service. Also, despite the withdrawal of rental assistance for the last few decades, New Orleans' marginalized communities still consisted heavily of rental

properties. In the aftermath of Katrina, in addition to the demolition of properties for low-income residents, rent has increased citywide by 43 percent, and only 15 percent of all rebuilding funds have gone to rental properties. Yet probably no greater example exists of the violence in recovery than the Road Home Program.

Residents were given the option of securing a grant to rebuild their home, taking fair-market value for their home and buying a home in Louisiana, or selling their home to the state and moving outside of Louisiana. While grants were to be made up to $150,000, the average grant in the Lower Ninth Ward was about $80,000. Admittedly, while the average value of a home in the Lower Ninth was only $90,000, the cost to rebuild those houses, however, was much more. Many homeowners therefore received much less than they needed to rebuild. Additionally, because of the time lag between securing a Road Home grant and the damage caused by Hurricane Katrina and the flooding (over a year), much of the money was used to pay off debts. Also, many residents have reported that their Road Home checks went directly to mortgage companies and/or insurance companies to pay existing claims rather than to them. In some cases the demand for the check came the same day as the claimant received it. Those that did receive Road Home funds were divested of them by what has become the largest instance of contractor fraud in US history. Residents were urged to pay contractors a significant percentage of the reconstruction estimate up front so that they could "jump the queue," only to never see the contractor again. Many contractors performed unlicensed or subpar work, leaving residents without the necessary certification to complete work or gain occupancy. Thus far very few contractors have been prosecuted. The result of the Road Home program has been that much of the money promised to homeowners has ended up in others' pockets. Finch et al. (2010) have found that the Road Home program actually ended up decreasing the number of returning households. Finally, despite being found to be racially discriminatory in its allocation, the program has initiated investigations against those who took the rebuild option but have yet to begun to rebuild.

Additional secondary violences have included severe environmental degradation (which has gone almost unnoticed), a dilapidated infrastructure, redistricting (which has bisected black communities—those hit the hardest by Katrina—and put them in white districts, effectively diluting the black vote), a system of egregious fines levied against homeowners who despite only having the vestiges of a home are forced to maintain the aesthetic condition of their property, and in the Lower Ninth Ward the failure to rebuild community spaces—including the Sanchez community center, which FEMA promised to help rebuild in 2008. These secondary violences have not only perpetuated the original destruction caused by Katrina, but have prevented residents from returning and have complicated the moving-on process. Furthermore, these violences are largely responsible for the uncertainty and confusion that dominates places like the Lower Ninth Ward.

Today the Lower Ninth Ward has retained about a quarter of its pre-Katrina population. It is in the words of its residents "the new frontier," "a dying place," "a wasteland," and "the edge." Much of the community has become a dumping ground.

Figure 29.3. Trash collected, and often simply dumped, sits on the side of the road in front of new construction waiting for removal by city services.
Photo by author.

Volunteers from non-profits and community groups who pick up the refuse and help cut lots are forced to watch as the refuse is replaced and the city fails to collect gathered items.

The city rarely assists residents with maintenance projects, requiring them instead to rely on volunteers or private companies that have sprung up in neighboring parishes. Infrastructure projects marked for completion in 2009 are not underway in 2012. Large-scale industrial equipment and trucks take up abandoned lots and block streets. The ground is polluted, and being in "Cancer Alley"—a seventy-mile stretch of land with close to two hundred petro-chemical and industrial facilities—many residents worry about the air they breathe. Residents wait for the city to help rebuild their community, they wait for additional grants to elevate their homes, they fight the Army Corps of Engineers who is seeking to build an additional deep draft canal to replace the MRGO, they wait for businesses and stores to return, and they wait for their families and friends to come home. And they wait for a pause in the secondary violences.

The question remains, however: How do we interpret the cause of these secondary violences? In an excellent paper, Chamlee-Wright and Storr (2010) note that two competing explanations have emerged to explain the failure to rebuild the Lower Ninth Ward. The first, favored by most social scientists, focuses on the structural and historical legacies of racism (see for example Dyson, 2006; Marable, 2010; Jack-

son, 2011), while the second is centered on the profit-seeking behavior inherent to disaster capitalism (see for example Klein, 2007; Gunewardena and Schuller, 2008; Adams et al., 2009). I would like to offer hyper-marginalization as a third possibility.

By hyper-marginalization I refer not only to the speed by which marginalization is accomplished, but even more so the aggressiveness with which it is pursued. It is not the by-product of policy or an indirect outcome of economic development; it is the status quo. Its goal is not only social exclusion, but social abandonment. Furthermore, it is directly understood by the marginalized as an intentional, purposive phenomenon. Inherent to my conceptualization of hyper-marginalization is that in an age of neo-liberalism and climate change it is becoming more common. Disasters and other large-scale instances of social disruption will permit its implementation under a cost-benefit rubric, furthering previous marginalizing projects to their logical end.

While hyper-marginalization has several features in common with other forms of marginalization, especially what Wacquant (1996, 2008) calls "advanced marginality," such as the "penalization of the poor" (Wacquant, 2009), or "lumpen abuse" (Bourgois and Schonberg, 2009), there are some important differences. First and foremost, as Wacquant (1996, 2008) and others (Rios, 2011) have noted, marginalization has primarily been about surveillance and social control. Minority groups are circumscribed into spatially delineated areas to be constantly monitored and policed. In hyper-marginalization, social abandonment replaces social control. Domination depends not on harassing and policing a subordinate population, but rather is achieved by ignoring them. The members of the community are positioned to regularly ask the dominant group for basic human rights and services. Services such as places to buy food, potable water, utilities, and accessible streets, which are often taken for granted in other communities, must be negotiated in hyper-marginalized spaces.

Second, whereas the retrenchment of the welfare state is a consistent characteristic of marginality, in hyper-marginality welfare and aidfare, albeit temporarily, replace wage labor. While the Lower Ninth Ward had been subjected to marginalizing practices throughout the 1980s and 1990s, many residents were still working class and owned their homes. After Hurricane Katrina, however, many have been forced to borrow money or use aid to rebuild their homes. Many had to quit their jobs to focus on rebuilding. Additionally, as has been celebrated elsewhere, the median income of New Orleans actually increased after Hurricane Katrina, in part because of the disappearance of those in poverty, but also because of the loss of lower-class jobs. While many of those who have been hyper-marginalized would like to work and possess the necessary skills to work, they have been frozen out of the rebuilding industry by volunteers and out-of-state workers. Many former working-class jobs are done by undocumented workers who work below minimum wage and by volunteers who actually pay non-profits to help with the work.

Finally, as would be imagined, the speed with which the marginalization takes place is both quantitatively and qualitatively different in hyper-marginalization.

Whereas many inner-city ghettos and rust belt communities in the US were marginalized over the course of decades, the hyper-marginalization of the Lower Ninth Ward occurred in less than a year (some would say in a couple of minutes). It was in that time that the city and other institutions (what might be called the *disaster politico-corporate complex*) decided it was not profitable enough to bring back the Lower Ninth. Likewise, the speed with which a community is hyper-marginalized brings its own cognitive and social-psychological concerns. Strategies and decisions which are temporally elongated in traditionally marginalized communities must form in a temporally atrophied situation and often under acute stress.

It is not, however, the purpose of this chapter to compare hyper-marginalization to advanced marginalization. The similarities between the two far outpace the differences. And it is certainly not the case that advanced marginalization has come and gone. But in order to understand the processes of marginalization, we can no longer ignore its most socially vile and volatile form. I use the remainder of this chapter to note some of the defining outcomes of hyper-marginalization and how they have affected residents of the Lower Ninth Ward. Here I draw on my ethnographic experiences in helping to rebuild the Lower Ninth Ward and thirty-seven semi-structured interviews that took place from 2010 to 2011.

(1) De-Individualization

In the days immediately following Hurricane Katrina, many citizens became entrenched in the dehumanizing process of proving their lawful citizenship. Katrina was used as an excuse to criminalize and incarcerate those who in the midst of a disaster were deemed to be non-citizens. These practices were extended to the point where people were reduced to being documents. This process became codified under the Road Home program, where residents had to prove direct ownership of their homes in order to receive rebuilding grants. In the Lower Ninth this proved to be a major obstacle to rebuilding, as many homes had been handed down to family members over a period of generations. These homes were "family homes" where cousins, uncle and aunts, and grandchildren could stay until a more permanent place became available. In many cases the legal owner was deceased, having never officially willed the property to any particular individual, or the property was legally owned by several family members. The end result, however, was the same; former inhabitants of the space were prevented from rebuilding their property. In several instances this obstacle caused further violence as families became disrupted, separated, and later fought over property rights. The family unit was replaced with the capitalist orientation of legal owner. Likewise, people were no longer seen as members of the community, but simply as property owners.

One resident who lost family members during the flooding counted himself lucky because the documentation he needed to prove he owned his home survived. While others who returned to the neighborhood in the months after Katrina scrambled to find documents, he was able to use his documents to become one of the first own-

ers of the famed Make It Right houses. While still grieving for his family, he had nonetheless appropriated the language of de-individualization to make sense of the aftermath of Katrina.

> Yeah, I was definitely one of the lucky ones. I don't think people realized, they do now, for sure, the importance of being able to show what you had . . . and the condition. I tell everyone take pictures and keep them safe . . . and save everything. All that paperwork you don't think is necessary, that's what separated us, those people who are back, they had their paperwork and those still struggling to get their homes back, they didn't, don't have it. I was lucky man. I mean it. I suffered, but I had my papers . . . hurricane didn't take that away. (Sean, black male, 60s)

Paul's experience was different from Sean's but still demonstrates the internalization of the de-individualization process. Paul's family had lived in the Lower Ninth for almost a century. His primary and extended family had at one time occupied over a half of a block, but by the time Katrina hit only his mother remained and most of the other homes had fallen into disrepair. Paul was determined after Katrina to fix all of the homes that his family had owned but soon found that his mother did not have clear title to all of the houses. Furthermore, family members were challenging his ownership status for the remaining houses. In the years that followed Katrina a bitter and apparently un-resolvable situation arose whereby Paul could not receive money to work on the homes, family members refused to sell him their rights to the home, and the city prevented him from working on the homes until he could demonstrate ownership. After exhausting other options, Paul used the legal status of his father's business, of which he had been a partner, to acquire one of the homes, despite that the business had not really been operable for several years. The business had at one time operated out of one of the homes and still held the deed. After proving ownership of that home, he used the business as a front to buy other houses at an auction. Eventually family members sold him their rights or stopped contesting his claims. Paul explained while working on one of the homes one day,

> I, we, wouldn't be here today, if I hadn't done it. I feel bad because there is no business and I know that's why I got the houses and why we continue to get volunteer help, but what would this be . . . these houses will be used again, you know. It's funny though because I had to do something I wouldn't normally do, wouldn't have thought of doing, to get it done. (white male, 40s)

As an individual Paul could not, in his words, "get it done," but as a business he did in a few months what he had not been able to do in three years.

Again, I do not claim that de-individualization is new to marginalization, but in hyper-marginalization it is manifest. People have internalized this strategy and use it as a tactic for dealing with the marginalizing process. Lee, for example, helped run a bicycle shop in the Ninth Ward before Katrina and has put most of his aspirations into rebuilding a bike shop. But Lee was a renter before Katrina and has thus not received any financial assistance. Lee squats in a 15 x 10 square foot mobile home and

spends most of days at various non-profits, helping cook meals, telling volunteers stories, and using the resources of the non-profits. Although he has a business plan, because he is unemployed and has very little collateral, he has been unable to acquire a loan for the bike shop. Yet while several financing opportunities have presented themselves, Lee has refused to be a participant to them. Having observed the moderate success of non-profits in attracting funds, Lee wants to become a non-profit.

> That's the way man. I can't do it no other way. I just got to get my status. If I can be a 503, then I can get money. Ain't no one giving money to Lee. But people will line up to give money to Lee's organization. That's the way they all do it. You ain't doing it, you gonna fall behind. That's the way I'll get my bike shop, see. I know lots of people that are individually poor, but 503 rich. (black male, 50s)

The lesson learned by many residents from Katrina was in the event of an emergency to prioritize documentation above all else. When asked what they would do differently, people rarely mention evacuating earlier or taking family mementos, they spoke about documents. They have accepted that in the aftermath of severe social disruption, documents, or being able to prove who one is or what one owns, is more important than people.

(2) Spatial and Social Coarctation

Coarctation is the process of becoming pressed together or narrowing, constricting, or confining to a narrow space. Residents describe the Lower Ninth Ward pre-Katrina as a communal landscape. One knew where one was by who was sitting on the front porch or working in their yard. Lee described it as a series of smells that connected the homes to streets and the streets to the larger community. But this community has been drastically confined since Katrina.

> Ahh, you knew where you were, now . . . I'm talking, I'm not talking about time of year, but you knew that too, you knew what street you were on or whose house you were near because of the smells. It isn't like that no more. You know that smell of grease? Like fish frying. You know, I know you know. You don't have that anymore. The shrimps, the cabbage, you knew where to get the sugarcanes and corns, right now this time of the year, you, we would be smelling that sugarcane. It's like everything went inside. Everything good went inside and don't come out no more. (black male, 50s)

When asked about the safety of their neighborhood some residents would speak in terms of rigid boundaries, naming streets that properly define the neighborhood—which is not difficult to do as it is hemmed in by levees and a canal—but others used flexible or fuzzy boundaries. It was apparent that they no longer knew how to speak about the neighborhood. Because large parts of the neighborhood remain abandoned, it is not clear to some residents if those spaces are still part of the neighborhood. For others, a tactic of dealing with the blight and disorder was to narrow one's mental image of the neighborhood. William (white male, 50s) adopted this tactic

most clearly. When asked how the neighborhood was doing William spoke of his two neighbors and a house "over there." Commenting on the safety of the neighborhood, William said he knew there were some problems somewhere in the neighborhood, but that "this street" was fine. William's understanding of the neighborhood stood in opposition to him being a past board member of the neighborhood association and the fact that I often spoke with him outside of the neighborhood. Many interviewees repeated William's understanding of the neighborhood, speaking of the neighborhood in terms that made it obvious they felt it had become constricted.

> This section is doing well. I mean we're not all back. We saw that yesterday working [when we boarded up some neighboring homes], but this part is good. It's kind of its own little, a little place of its own, separate from everything else, from what's going on out there. It affects us. But not as much as if we were in it. I mean you know it [the neighborhood's problems] is out there, but they don't affect us as much here. (Gloria, black female, 60s)

Like others, Gloria spoke in general terms about the rest of the neighborhood. It is "out there" somewhere, and like others had mentally cordoned off parts of the neighborhood that threatened their progress narrative. Still others, however, simply do not go into the neighborhood any longer. Rather than just narrowing their image of the neighborhood, they have narrowed their interaction with the neighborhood.

> It's not safe, no, it's not. I use to walk these streets every day. I'd say Hi Mrs. Peters, Hi Mr. Tye, Hello Miss Ava. But they ain't there no more and it's not good for me to walk around by myself. No police, nothing. What's to stop someone from doing something to me? Who would even see it. I just sit here on my porch. . . . I like it. I wish I could see my neighbors again. I had good neighbors. I would walk and watch the kids playing and talk to everyone. I'd walk to the store. I'd cross Claiborne [one of the two main streets that bisect the community]. I'm lucky to cross Charbonnet now [her street]. Not no more, Lordy no. You walk around, you know, you don't see no one on these streets, not no more. (Helen, black female, 80s)

Likewise, Darren (black male, 40s) spoke of social practices that have been narrowed. "You used to sit on your porch and wave to everyone. You know everyone. Now you don't wave to no one and no one waves to you. You just don't know anybody any more."

Post-Katrina, the boundaries of the Lower Ninth have narrowed. This is in part due to the fact that more than half of the Lower Ninth Ward is uninhabitable, but it also owes much to the myopic view of who counts as a neighbor. Sitting with Darren on his front porch for over two hours, I saw two dozen or so people honk their horns and wave hello, and several people walking by stopped to see what we were doing and how Darren was feeling. Darren's family, however, is from a different part of the neighborhood and have been well known for decades (his father and uncle were both postmen). Darren said that the neighborhood was not what it used to be. He explained that he used to go back and forth between Holy Cross and the Lower

Ninth and now that he lives in Holy Cross he doesn't see the people he used to know. He blames the city for not rebuilding the Lower Ninth and sees the spatial constricting in social terms, even if to an outside observer the change is not as apparent. What matters is that Darren believes his social options have been constricted.

Finally, while neighborhoods like the Lower Ninth Ward have always had fairly non-porous boundaries[4]; post-Katrina the difference between outsiders and insiders has become heightened, despite, or perhaps in part because of, the influx of millions of volunteers, that community boundaries have been drawn tighter. In a neighborhood where people have lived for generations (the mean year in which people report having moved to the Lower Ninth Ward is 1974), it is easy to be counted as an outsider. Disasters like Katrina, however, have a way of even creating differences between neighbors. One resident told me he couldn't relate to his neighbor because he hadn't gone through what he had, meaning since his neighbor had been able to rebuild and he had not, the neighbor had not suffered enough to count. At community meetings, location could become a contentious issue. It was commonly said, "you might be from here but you ain't *from here*." Because the neighborhood had not been rebuilt, because people were forced to move to different parts of the neighborhood, and because services have not been restored, boundaries, both mentally and physically, have become tightened.

(3) Territorial Ambiguation

Wacquant (1999, 2007) notes that territorial fixation and stigmatization and spatial alienation are defining features of advanced marginality. Members of the community, but also outsiders, vilify the neighborhood. Being from "there" "disqualifies," "dishonors" and "disables" residents from social acceptance (Wacquant 2007, p. 67). In hyper-marginalization, however, while territorial fixation and stigmatization occurs, the initial disaster and, to the degree they are known or acknowledged, the secondary violences, complicate the status of the outcast. Many outsiders still see the Lower Ninth Ward as a ghetto, as a place for social refuse, but others see it as a socially abandoned community and sympathize with residents who understand their situation as first and foremost a violation of the social contract. Likewise, some residents believe that Katrina acted as a moral filter, separating good citizens and community members from criminals; only those individuals who want to make the community succeed have returned. Other residents, however, see the community as basically a microcosm of what existed before. This paradox of place represents what I call *territorial ambiguation*. As a feature of hyper-marginalization in the aftermath of social disruption, it captures the tendency for disasters to both obviate and fixate the meaning of place. Places like the Lower Ninth Ward retain their original stigma—it is ensconced in the collective memory—but it also projects a number of possible futures.

The Lower Ninth Ward is a territorial paradox. It is a place where social indignity coexists with social indignation. Residents are at times ashamed of being from the Lower Ninth and at other times proud of the neighborhood.

> The fact that we came back when no one [sic] counted us out says a lot. I mean we were left for dead here. No one cared about the Lower Ninth then. This place might not be much, but you should a seen it back then, back, just like a year ago. I mean we really go through up and downs here. But there ain't no place like the Lower Ninth. We always come back. And we come back better and stronger. (Carl, black male, 30s)

> Yeah it's rough man. No one has done this before. No one has taken a community like this, that suffered through something like we did, I mean this place was bad before, but 100 percent of this community left, that's never happened before and then rebuild it. But you see. It's looking good. We still have some problems . . . only 25 percent of us back . . . we need schools . . . but this place is going to be better than before. It's going to be better than it ever was. (Mel, black male, 50s)

The Lower Ninth even post-Katrina has retained its moniker as the murder capital of the murder capital, and yet on any summer day you can see high school–aged girls from Northeastern prep schools carrying rebuilding supplies down side streets. This flux of normalcy and normlessness can be extremely disorienting to residents. Chuck gives one of the best examples of this in a conversation on whether or not the neighborhood is coming back.

> Ahh man, just like the other day that thing happened. You drive around and you see, I know you know cause you out there man, you see people cutting grass, picking up things, planting trees, painting. And you get a good feeling and all, all right. It looks good. Then someone gets shot up and you be like same thing different day. I mean how can that happen. How is it, you know, you got this good thing and then this really bad thing. I don't understand. (black male, 40s)

The event Chuck referred to was a beautification project to celebrate what would have been the birthday of Pam Dashiells, a community activist who died in 2009. The event drew a consortium of non-profits and Senator Mary Landrieu, who used the day as an opportunity to bus in potential donors for possible infrastructure projects for the Lower Ninth. While the event was protested by a community group as a photo-op for Landrieu, the local bus stop was rebuilt, trees and grass were planted, and an area dedicated to Dashiells was replanted and cleaned up. The event was considered a success by most. Later that afternoon, however, just a few streets from where the Senator and non-profits had worked, a young man was killed in a drive-by shooting. The two events, separated by a few hours and a few hundred yards, make both the space and narrative of the neighborhood ambiguous.

The result of this territorial ambiguation is a place that was at once dangerous, yet peaceful and safe. Residents want to project a sense of home and security, but at the same time, are forced to acknowledge the emptiness of the neighborhood. This ambiguation produces a good deal of cognitive dissonance. At town halls and community meetings, residents bring up problems and issues that they believe prevent their neighborhood from moving forward, but in many conversations and in formal interviews they describe the neighborhood as "a good place to live" and as a "place

you want to raise your kids." They are at once protective of the neighborhood's identity while simultaneously worrying about it becoming something other than a marginalized neighborhood.

(4) Ethno-Racial Distanciation

Hyper-marginalization has in common with advanced marginality, and other marginalizing projects, a naturalization of ethno-racial differences. Just as the rise of the second ghettos in Chicago, for instance, seemingly naturalized racial differences by first creating and then defunding and hyper-policing public housing, as middle-class whites and blacks were replaced by lower-income residents, the social abandonment of the Lower Ninth Ward has fixated a stark contrast between its progress and the visible progress of other areas. Volunteers often interpret this difference as one of a racial work ethic. They often ask why more homeowners do not help with the day-to-day rebuilding effort. This expectation could be interpreted as the belief that if you are helping someone with their home they should be present and assist in some way. But volunteers generally work on houses weekdays during normal business hours. Many stay outside of the community. Their experience with community members is often reduced to interactions with people peddling CDs and DVDs at a gas station or unemployed men who gather to drink on the neutral ground. They do not realize that many homeowners are at work during the day or are still displaced in other cities. This is in contrast to other areas of the city where volunteers go, which are predominantly white and have been repaired. The result is that they experience the space as a dysfunctional black space that is in need of white assistance.

Additionally, because much of the aid and monies set aside for homeowners wishing to rebuild has run out, many of the non-profits now survive by creating make-work projects for volunteers. These volunteers can help homeowners who are in a position to benefit from unskilled laborers. Those homeowners who are in a position to take on these volunteers are most likely those who pre-Katrina had the most social or educational capital to now make use of available resources or tap into existing networks of aid. They are also likewise those people who have maintained an ongoing interest in the affairs of the neighborhood and are active in one of the neighborhood association groups or non-profits. In other words, these "overflow volunteers" are not put where they are most needed, on complete rebuild projects, but rather they are put on painting or gardening projects for those homeowners who are already in their homes. The returned homeowners are overwhelmingly white. Additionally, like Paul, who was mentioned earlier, these homeowners usually "donate" money to the non-profits or community organizations to jump the queue or to "remind" the association that they need some help. Again, white homeowners are in a better place to do this than black homeowners. The result is that black areas of the Lower Ninth languish, while whiter areas like Holy Cross have seen greater numbers of residents returning.[5] This not only creates a misunderstanding on the part of volunteers and

visitors of the structural and racial discrimination that affects the neighborhood, but creates animosity between residents of Holy Cross and the Lower Ninth.

Ethno-racial distanciation has occurred in other ways. Mel offered one day to drive me around and talk to the men on the neutral ground—a grassy area that divides a street where people congregate, usually during Mardi Gras and other parades, but can also be a unique space of social interaction for the unemployed or addicts. Despite that most marginalized communities in New Orleans have problems with people congregating and drinking on the neutral ground, Mel interprets the Lower Ninth's neutral grounds as proof of ethno-racial distanciation.

> These men ain't suppose to be there. They carpenters, electricians, plumbers, they have skills. These are the men that used to work. I know them. I grew up and I looked up to them. They went to work and earned a check. But now they sit out there and drink because they ain't nothing else for them to do. Make it Right told us, Brad Pitt told us, they'd make sure at least 60 percent of all the workers, because they hire skilled workers, would be from the community. We tell 'em all the time, they only got a handful of men from the community out there. It's a huge problem. We got men who could do the job and want to do it, they want to work. I ain't racist, we wouldn't be here without help, but most of the people getting jobs are either white or brown and they ain't from this community. That's a problem. So you have to ask why is that? I mean they promised us to get our blessing and then they just ignore us. I tell 'em every few months, you need to get people from this community working. [And what do they say?] They working on it. It's been three years and you want to tell me you still working on it? It's on purpose. But why? That's what you need to go ask them. Go talk to them and ask them why.

Mel's view of rebuilding is complicated. Like most residents, he is grateful for the volunteers who have helped rebuild, including his home and the community center he runs (which earns most of its revenue by housing volunteers), but he is wary that most of the skilled labor that is necessary for finishing plumbing or electrical work or certifying finished work goes to whites from outside of the community. He, as do many others, sees this as an intentional effort to weaken the community.

> We used to work. Now everyone is on some kind of governmental assistance. I don't like it. I don't like what it's done to this community. We used to be proud people. Now most of these men just sit around all day waiting for someone to help them. You asked me earlier what was the biggest change. That's it. I think that's bigger than the houses missing, we're missing work, those jobs. It's changed the way people think. They still got that mentality that they did right after Katrina. But for others, they want to work, but there ain't no jobs. The jobs ain't come back. And we got to keep asking why. (Amy, black female, 30s)

She acknowledges that people needed help after Katrina, but now they need jobs. Many places of employment that served poor communities have not been rebuilt, meaning those jobs have not returned. As the city proudly notes, New Orleans's median income has risen since Katrina. Part of this has been due to the removal of marginalized citizens, but a significant portion has been the removal of marginal jobs.

The advantages that whites accrued under urban marginalization before Katrina have been compounded and extended since Katrina. The result is the Lower Ninth Ward is experienced by visitors, volunteers, and some residents as a dysfunctional black space. They attribute the confusion, uncertainty, and apathy, to the residents rather than the social structure(s) which have created it and perpetuate its existence. The president of one of the two neighborhood associations told me, in regard to my research on how the community is responding to Katrina, that "the residents here ain't gonna do nothing, they don't know what to do, some of them don't even know something needs to be done." Despite being from the neighborhood and serving as one of its more prominent representatives, she attributed the inertia to the residents themselves. As others entered the room, she rose to greet them, and looking back she said, "this ain't Lakeview."[6]

(5) **Disaster Capitalist Logic**

Common to marginalized neighborhoods is an economic indifference as to what goes on in the neighborhood. While this usually takes the form of tolerating, perhaps even participating, in underground economies, in hyper-marginalization the indifference is exaggerated. In the aftermath of Hurricane Katrina one of the largest, if not the largest, instances of contractor fraud occurred. Contractors approached residents and offered to move them up their rebuilding queue if the resident would pay up front. It was also very common to pay a retainer to a contractor. And as is a common practice in the industry, contractors would bid a job and work for a few days/weeks to demonstrate that they "were on the job," until another job was bid and the process would be repeated. In places like the Lower Ninth Ward, however, where there were thousands of jobs, contractors would spend a few days working (if that at all) and then never return. Many residents have very emotional stories of losing significant portions of their insurance or Road Home grants to unscrupulous contractors.

> I should've known something was up. They's too nice. They, there's two of 'em, said they'd do it cheaper, said they get to it in a few weeks, if I write a check for $20,000. I send that check to a post office box. Police said whoever owned it, it was a fake or whatever. They said they has lots of complaints against those guys. And I knows who they is. I knows where they live . . . police ain't done nothing . . . said I could get a lawyer, but I ain't got money or time for a lawyer. (Henirietta, black female, 80s)

Following Klein's work on disaster capitalism, *disaster-capitalist logic* represents the extension of that process to its final conclusion. While Klein argues that neoliberal policies are pushed through by a small group of wealthy and powerful in the aftermath of disasters, disaster-capitalist logic represents the internalization of that logic by citizens. Many residents of the Lower Ninth understand that they are experiencing the shock of disaster capitalism and that people, including some in the community, still profit from Katrina, and this is a point of contention, but many regard it as inevitable. Who profits and how they profit furthers the marginalization.

Another aspect of disaster-capitalist logic involves a zero-sum game of community aid. Before Katrina there were no non-profits in the Lower Ninth, today there are thirty-three doing work there. These non-profits, despite having very different missions, compete for volunteers and grants. Often when a non-profit is awarded a large grant or receives a large donation, other non-profits publicly protest or break off relations for a period of time with that non-profit. And when a non-profit comes up with a new funding scheme, that scheme is attacked by other non-profits as a profit-seeking venture.

This logic is also reflected in social interaction (or the lack thereof). Neighbors often know what Road Home option others took and become bitter if Option One was taken and the neighbor has not taken any efforts to rebuild. Despite knowing the numerous obstacles to rebuilding with Road Home money, the neighbor who has rebuilt feels in some way cheated. More so, however, neighbors believe that others want to know how they got to where they are in the rebuilding process.

Both Henirietta and Helen no longer welcome visitors in their home. Part of the reason is that they are both elderly and live alone and understandably fear being the victim of a home invasion, but both also said that they do not want their neighbors to know that they are doing well. Thus, even as Helen laments the loss of her

Figure 29.4. A common sight in the Lower Ninth are homes in some state of repair, yet vacant, next to homes that have been rebuilt and are occupied. Neighbors often know how much money each other received to rebuild their homes, and because of widely disparate amounts this has created much tension.
Photo by author.

neighbors, she has sealed off her home as a possible space of interaction. Another resident, Marcus, explains this logic.

> A lot of people are doing better after Katrina. Everything is new. You know, new tv, new sofa, new fridge and ice box. But a lotta people ain't. A lotta people don't have these nice things and they look at what you got and they wanna know how'd you get that. You know, what did you get out of it? And it's hard because you don't know. I mean you want them to have nice things, you know, you want them to get fixed up, but you don't want them going around talking like Marcus gotta 45 inch flat screen, Marcus gotta new kitchen, Marcus gotta new stereo box. Because the first thing you know some cousin or someone hears them and Marcus ain't got nothing no more. Ya catch me. I used to have folks over from time to time. We'd have meetins here. Then I noticed people be looking around. And I thought . . . that's really no good. People get jealous and they look at you differently. (black male, 50s)

Marcus noted that neighbors assume that the other has committed some type of fraud or other crime to get where they are in the rebuilding process. The result is that rather than share resources many neighbors keep information to themselves. This is true of the non-profits as well. New grants or lines of funding, even if not applicable to the mission of a particular non-profit, are rarely passed along to those it could benefit. Rebuilding itself becomes a marginalizing phenomenon.

Perhaps the best example of disaster capitalist logic is what several non-profits call "volunteer trafficking." Community groups and non-profits charge volunteers for volunteering. The money goes to room/board or supplies. For many non-profits this money represents a substantial portion of their revenue. Many of these non-profits and community groups, however, are not organized to employ volunteer services. They have few, if any, actual projects to put volunteers on. Thus when they receive large groups of volunteers, they have to place those volunteers with other non-profits (usually for a portion of the volunteer fee). The non-profits who regularly engage in trafficking are similar to the contractors and other disaster capitalists that they abhor, but they differentiate themselves by referencing the good work that the volunteers do. Many of them internalize the disaster capitalist logic by noting, as one director of a non-profit did, that in the context of the post-Katrina Lower Ninth Ward "the calvary ain't coming, we got to save ourselves."

(6) Symbolic Repair

Much of the rebuilding and recovery efforts in the Lower Ninth Ward can only be seen as symbolic repair. Having worked with the mayor's office on blight remediation projects, these efforts can only be understood as symbolic attempts to demonstrate to residents that some progress is being achieved towards making them whole again. Much like the event that Senator Landrieu participated in, which was protested by a local non-profit yelling "photo-op," trees and flowers are planted rather than schools and health clinics built. Likewise, because many non-profits can only supply volun-

teer labor and are limited in the monetary or material contributions with which they might assist homeowners, many volunteers are engaged in lot clearing and gardening projects. While their lack of skill and short time spent in the community prevents them from significant participation in rebuilding projects, these "make-work" projects are interpreted by homeowners as "window-dressing" that allow the non-profits to keep functioning and politicians to stay in office.

The symbolic repair, however, slowly erodes the hope of residents that something meaningful will be accomplished. One resident noted, for instance, that he has seen the same lot cleared four times now, while the two structures still standing on his block are in need of being demolished. Another resident commented that he has seen groups of volunteers with different non-profits work in the same lot on consecutive weekends. These kinds of projects also alienate volunteers, several of whom mentioned having cleared lots the previous summer or spring break only to return and find those lots in need of clearing again.

Because of the severity of structural problems in the Lower Ninth undue focus is given to aesthetics. While many of these projects are labeled as blight remediation, very few are concerned with the demolition or removal of structures that are beyond repair. Residents question the asymmetry between small and large remediation projects and argue over which project should be the focus of the community. When it was announced in summer 2011 that $45 million would spent repairing the roads of the Lower Ninth (New Orleans is annually reported as having the worst roads in the US) many residents objected that the money was not going toward the building of a school, the creation of park/public space, restoring sewer/water systems, or levee projects. Other New Orleanians questioned spending money on roads for a community that is in such disrepair. Thus even when large-scale remediation projects are undertaken they are viewed as symbolic.

CONCLUSION

The sixth anniversary of Hurricane Katrina and the federal levee failures were marked with dozens of stories of commemoration and the aftermath of a hurricane. But the hurricane was Irene, which at the time posed a serious threat to the Northeast, and the stories on commemoration were about 9/11. And yet in the midst of preparing for what some were calling the East Coast's "storm of a lifetime," members of Congress and presidential hopefuls were calling for the abolition of the Federal Emergency Management Agency. At the very least, it was noted, we can no longer expect the government to pay for disaster relief without cutting spending elsewhere.

In an age of neoliberal policy and fiscal austerity measures, the idea of robbing Paul to pay everyone else is becoming increasingly popular. We cut back our spending on housing, roads, hospitals, and other public works projects so that we can provide some relief in the aftermath of disasters. But that relief goes to the middle or upper class and to projects that benefit them. Marginalized neighborhoods are

regarded as sunk-costs. The damage and destruction wrought by the disaster is simply naturalized. It becomes part of the environment; a characteristic of the people who inhabit the community.

In this chapter, I have argued that we are witnessing a new form of urban marginalization. It is not the case that older forms of marginalization have become obsolete. Unfortunately those marginalizing projects are still with us. Rather, what I have argued is that disasters are increasingly being used to further the process of urban marginalization. As one Louisiana Congressperson noted in the days following Hurricane Katrina, "[w]e finally cleaned up public housing in New Orleans." It was assumed that what social policy could not do in decades, Katrina did in seconds. I call this form of urban marginalization hyper-marginalization. It is accomplished by various kinds of secondary violences that punish and abuse the marginalized. Nowhere have these violences been as evident as in the Lower Ninth Ward.

The Lower Ninth Ward is the proverbial canary in the coal mine. Communities have been abandoned in past aftermaths, but not with the speed and aggression of the Lower Ninth Ward. Residents of Joplin, Missouri, are now being told that there is no more money for rebuilding their community. Most of Haiti looks like it did in the days after the earthquake. As with the Lower Ninth, the bodies have been removed, some of the rubble relocated, but very few of the poorer neighborhoods have been rebuilt while businesses and services for the wealthy have been restored. Disasters are increasingly being used as an excuse to exacerbate and extend the conditions of urban marginality.

For the marginalized this hyper-marginalization feels like social abandonment. It is perceived by many in the community as a violation of their civil, even human, rights. They speak of the last six years largely in contractarian terms. They are acutely aware of their marginalization in a way in which they never were before.

> Nothing comes easy, it's always a fight . . . a lot of us are a lot more aware of things than we were before, politically, we have to be. We have to . . . it is about advocacy and justice. Ain't no other place like, like the Lower Ninth Ward, not today, not in America. We're an island, an island of abandonment. Tour buses come and look at us, looking at Katrina's damage, but they might as well be watching the neighborhood that care forgot. And it ain't care either. Lots of volunteers have come and helped, people that ain't never heard of us, but politicians, the money, the help we really need, it ain't come. It's like they want to punish us . . . and I'll give you an example . . . [I] went through the handouts, at the last NORD [New Orleans Recreation Department] meeting, they gave us handouts, and saw that all the [summer] camps in the poor neighborhoods were fee based and all the camps in the wealthier, whiter neighborhoods, District A and B, were not fee based . . . why are these camps fee based? They setting us up for failure. That's what they are doing. And I told them why. I went up to the podium. What they going to do is when, I brought up, what's going to happen is families here aren't going to register their kids, it's unaffordable, so next year they going to say they no need for these camps in these neighborhoods. Camps won't even be an option. That's how they do it. They don't want us to come back. (Wendy, black female, 50s)

This form of urban marginalization is perhaps the most pernicious. The policies that support it view the marginalized as something other than citizens, as something to be isolated and excluded. In the aftermath of a disaster, when the marginalized most need help and where the opportunity for social justice is most present, current policy dictates social abandonment. Of the many lessons learned from Katrina, this is perhaps the most important.

NOTES

1. Residents were not told what their destination was until they arrived in their host city. This "evacuation" was at times done at gunpoint.

2. It should also be noted that in 1960 the schools in the Lower Ninth Ward were forcibly integrated. By lunch most parents had taken the remaining white students out of school, and by the end of the week they were registered in St. Bernard Parish. The three black students and one white student at McDonogh No.19 went to school by themselves for an entire year. Whites responded by passing new Jim Crow legislation (forty-three new pieces of legislation in 1960 alone) and eventually by moving to neighboring parishes.

3. I would argue that the rebuilding progress in more marginalized areas has stalled and differences have become more exaggerated since their data collection in June 2008.

4. Missing from much of the "Katrina literature" is the fact that New Orleans, much like New York City or Chicago, has very distinct neighborhoods. These neighborhoods and their schools have long been a primary source of identity for residents. Compounded with the racial history of New Orleans, these neighborhoods have often served as very rigid demarcations of who belongs and who does not.

5. The Lower Ninth section of the Lower Ninth Ward was 2 percent white before Katrina while Holy Cross was 11 percent white. Post-Katrina, however, the differences have become more exaggerated. While reliable numbers are hard to come by, the Lower Ninth section stands at 1 percent white while Holy Cross's white population ranges anywhere from 15 percent to 20 percent. Furthermore, certain sections of Holy Cross are majority white.

6. The Lakeview area is one of the more wealthy and whiter areas of New Orleans. While it as lost about 35 percent of its pre-Katrina population and suffered a level of destruction comparable to the Lower Ninth, it has faired significantly better post-Katrina than the Lower Ninth. While many residents of the Lower Ninth believe that race has been the deciding difference between the two, others, like the speaker, believe it has more to do with civic pride.

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Selling Out

A Case Study of the Transition from Rental Control to Market Rate Housing in New York City

Rachael A. Woldoff, Lisa M. Morrison, and Michael R. Glass

> *Peter Cooper Village offers one and two bedroom luxury rental residences in the heart of downtown Manhattan. Set within a beautifully landscaped 80-acre park, the spacious apartments feature hardwood floors, high ceilings, and sophisticated appointments. Amenities include a state-of-the-art fitness center, resident's lounge, kid's playroom, screening room and study and offer conveniences unrivaled in Manhattan. On-site parking, easy access to mass transportation, and 24-hour on-site security help further distinguish Peter Cooper Village. Situated near Gramercy Park, the Flat Iron District, Union Square, and the East Village, living at Peter Cooper Village is truly Manhattan without sacrifice.*
>
> (2009 website for Peter Cooper Village)

It is well known that finding an apartment in Manhattan is a nightmare. Misleading newspaper ads, Craigslist bait-and-switch tactics, expensive real estate brokers, lease problems with sublets, and landlord bribery are all common experiences for those scavenging for a place to live in a city where housing has become so expensive and housing stock so scarce. It is no wonder that when people read the advertisements that say that "you'll love everything" at this new version of Stuyvesant Town, their excitement is tempered with skepticism.

Upon reading the advertisement, apartment seekers, once overcome of their initial doubt, are likely to envision the modern luxury high-rises that have become ubiquitous along New York City's skyline in the past ten years. Aside from the mention of its "park-like setting," the words on the website above could be applied to dozens of new apartment developments in the city. Recently, the marketing materials for Peter Cooper Village and Stuyvesant Town (hereafter called "Stuy Town") have described them as "two iconic properties." One advertisement mentions that they are "located in the heart of New York City" and "each community

has its own distinct personality, lush green space, exclusive urban amenities and conveniences, and space rarely found in Manhattan." Yet apartment seekers coveting these "spacious apartments" might be surprised to learn that this housing complex was originally rent controlled and is only now in the process of a makeover and conversion to "luxury," market-rate status. Still, Stuy Town with its dozens of "cookie cutter" brick buildings (Finn, 2006) has a long and less glamorous history in New York City, and the alteration of this community has been the source of much controversy.

In 1943 New York City approved plans for a unique social experiment. Faced with the challenge of planning for the predicted post-war boom in housing demand, New York Housing Commissioner Robert Moses embarked on an ambitious plan to redevelop a sixty-acre area of Manhattan's Lower East Side known as the Gas House District. Moses's plans for the Gas House District were part of his broader objectives for the La Guardia administration to reshape the social geography of the city through large-scale redevelopments of so-called slum areas, including Harlem and Brooklyn. The Gas House District plan called for the removal of 11,000 working-class tenants to make way for high-rise buildings containing 11,250 apartments for middle-class families (Schwartz, 1993; Zipp, 2010).

Instead of the New York City government taking the lead in the planned redevelopment, Moses entrusted the Metropolitan Life Insurance Company (MetLife) to transform the Gas House District into an urban oasis for middle-income Americans, especially World War II veterans who were soon to return home. The partnership between MetLife and New York City would become an early template for the public-private developments that ultimately reshaped U.S. cities for the next fifty years. In general, public-private partnerships involve city governments identifying parcels of land to be redeveloped and providing subsidies for private developers who agree to spearhead the projects. The standard critique of such partnerships (and particularly those that occurred in the mid-twentieth century) is that whereas the public sector absorbs the risks for redevelopment, the private partner stands to gain most of the benefits accruing from the final project (Harvey, 1989). Furthermore, the rhetoric of urban renewal often fails to acknowledge that redevelopment can come at a cost to local residents who may become disenfranchised and/or displaced.

Two historic legislative actions made the project possible: 1) the Emergency War Tenant Protection Act, which capped the rents that could be charged to residents; and 2) the State Redevelopment Companies Law of 1942, which was designed to encourage private investment in housing through enabling the city to grant the right of eminent domain and a twenty-five-year tax abatement to MetLife. Over the years, the strict ceilings and rules of rent control have been loosened into a designation called "rent stabilization," which protects tenants from sharp rent increases. Recently, many Stuy Town apartments have been converted to market rate, which has significantly changed the character and demographics of the community. This conversion would have rewarded private investors to the detriment of the public who originally subsidized the development costs. Therefore, the Stuy Town case reflects

a deepening of global neoliberal principles (i.e., market-driven approaches) in local urban housing markets wherein the concept of housing developments as the basis for community is supplanted by investors seeking only profitable returns (Zukin, 2009). MetLife sold the properties to property developer Tishman-Speyer in 2006. The developer's inability to extract sufficient rents from Stuy Town contributed directly to a 2010 default which left thousands of residents insecure, and investors, such as the California Public Employees Retirement System, also suffered major losses. The default may have also signified a failure of prevailing neoliberal principles to generate profit for capitalists and provide stable communities in urban housing markets.

RENT CONTROL: A CONTESTED POLICY

"Rent control" laws can be broadly seen as a set of legal measures that municipalities originally enacted to increase the supply of affordable rental units in prohibitively expensive housing markets. The U.S. first adopted rent control legislation during World War II as a response to acute housing shortages, but administrators in many communities continue to use these laws to address a broad array of housing problems. It is impossible to appreciate the history of Stuy Town without an understanding of the larger history of rent control in New York City. Not only did rent control policy contribute to the construction of Stuy Town, but it also protected the community's tenants for over fifty years. Today, most Stuy Town tenants remain protected by these laws, but as rent-protected tenants either die or move away, the transition of apartments to market rate continues. The topic of rent control is highly contentious, with the main conflict between those who argue that rent controls distort the rental market and those who claim that rent controls are necessary to provide affordable access to specific housing markets. Past academic research on rent control has focused on four general topics: 1) the importance of rent control for vulnerable groups (especially in the face of natural disaster); 2) the rising privatization of urban space; 3) the struggle for renters' rights and related landlord conflicts; and 4) the effects of rent control on the quality, quantity, and price of housing. We briefly elaborate on each of these below.

Vulnerable Groups

Many researchers are interested in rent control policy because vulnerable groups in nations across the globe depend on these laws to meet their shelter needs. Housing vulnerability is a relative term that varies significantly from market to market. Historically, rent control legislation and definitions of vulnerability have been tied to two main circumstances: natural disasters and acute housing shortages.

Related to the former, groups who live in geographically vulnerable places, such as regions where natural disasters have destroyed the local housing stock, can be seen as highly vulnerable. Without rent control implemented in such communities, vacancy

rates decline, housing costs increase, and renters and other marginalized groups are "squeezed" from their neighborhoods (Pais & Elliot, 2008).

In the case of housing shortages, it is well known that rising housing costs are especially damaging to disadvantaged groups, yet local governments rarely support or implement rent control as a response. For instance, in the face of the rising housing costs in Canadian cities, public opinion was in support of anti-poverty policies, yet government officials refused to implement rent controls (Gazso & Krahn, 2008). This resistance to rent control was associated with the larger issue of declines in public assistance caused, in part, by public officials' rural bias and their decisions to cut welfare programs benefitting urban populations.

In the U.S., officials implemented rent control laws after World War II and during the 1960s and 1970s in order to aid homeless populations and military veteran groups in New York City and several California cities (Niebanck, 1985). However, these standards of vulnerability do not apply to contemporary New York City residents seeking rent control. In the New York City case, the definition of a vulnerable population is broader, including not only low-income families but also senior citizens and middle-class residents. Arguably, these groups would have very little presence in the city without rent control because of the dearth of affordable housing in Manhattan where median monthly rental costs in 2009 were the twelfth highest among U.S. cities ($1,243 per month) and median annual household incomes were twenty-fifth highest ($68,706) (Been et al., 2010). This is particularly significant for Manhattan's Stuy Town neighborhood, which has among the highest median household incomes and median rental rates in the city (table 30.1). Rental units covered by some form of rent stabilization have declined in recent years, with Manhattan experiencing a decrease to 54.5 percent of units in 2009 from 82.8 percent in 2000. According to the New York City Rent Guidelines Board, as recently as June 2011, public officials strengthened rent stabilization laws, placing further limits on landlords' abilities to raise rents, but the current luxury deregulation limit of $2,500 has not risen sufficiently to keep up with inflation.

Rising Privatization of Urban Space

Some have asserted that the declines in rent control are a consequence of a broader trend: the diminishing democratic control of U.S. cities. Mitchell and Beckett (2008) discussed municipal spending and the rise of the Municipal Services Corporation (MSC), which was created after the New York City financial crisis in the 1970s. According to the authors, the city "shifted funding away from sites of collective consumption and towards business-friendly ventures in the areas of real estate, producer services, banking, and insurance" (Mitchell & Beckett, 2008, p. 83; see also Fitch, 1993). The casualties of this event included tuition waivers at New York City's CUNY schools, "subsidized housing, rent control, transportation subsidies" (Shefter, 1985, p. 147). Though he failed to do so, New York mayor Rudy Giuliani also sought to end rent control along with efforts to privatize several city hospitals (Weikart, 2001).

Table 30.1. New York City Rental Market Statistics, 2000–2009

Variable	*Area*	*2000*	*2005*	*2009*
% Rent Regulated Units	Stuyvesant Town/Turtle Bay	75.8%	63.9%	48.2%
	Manhattan	82.8%	67.6%	54.5%
Homeownership Rate	Stuyvesant Town/Turtle Bay	26.3%	29.8%	34.1%
	Manhattan	20.1%	23.6%	25.1%
Median Household Income	Stuyvesant Town/Turtle Bay	$78,811	$76,010	$98,701
	Manhattan	$50,000	$50,000	$68,706
Median Monthly Rent	Stuyvesant Town/Turtle Bay	$1,472	$1,469	$1,881
	Manhattan	$1,186	$1,150	$1,243
Poverty Rate	Stuyvesant Town/Turtle Bay	7.9%	8.0%	6.9%
	Manhattan	20.0%	14.6%	16.6%
Rental Vacancy Rate	Stuyvesant Town/Turtle Bay	2.5%	2.9%	3.4%
	Manhattan	3.4%	3.8%	4.4%
Total Population	Stuyvesant Town/Turtle Bay	136,152[1]	136,152[1]	155,527
	Manhattan	1,537,195	1,606,275	1,585,873

Data obtained from Furman Center (2002, 2006, 2010) State of New York City's Housing & Neighborhood Reports.
[1] Stuyvesant Town/Turtle Bay neighborhood population counts from 2000 Census.

Such shifts from the public provision of housing toward privatization are considered part of the neoliberal political and economic orthodoxy of capitalist societies in the late twentieth century (Brenner & Theodore, 2002). Neoliberalism is a defined as a new manifestation of classic eighteenth-century liberal political ideology that holds that individual self-interest leads to the common good and that the free market knows best. In its late twentieth-century manifestation, such beliefs are actively supported by the exercise of state power at a variety of geographic scales (Smith, 2002). Neoliberal strategies including the privatization of state-owned assets, the use of public-private partnerships for urban redevelopment, and the gradual privatization of formerly public spaces all threaten to alter the character of urban environments and communities (Mitchell, 2003; Zukin, 2009).

The Struggle for Renters' Rights and Landlord Conflicts

Documented cases across decades have shown that conflicts between tenants and landlords (both large and small scale) are a key feature of the rent control debate in the U.S. Dating back to the 1950s, landlords viewed rent control laws with disdain. For example, one study of rent control in Honolulu in 1952 investigated landlords' perceptions of the policy, finding that landlords who opposed rent control and believed it was unfair and unnecessary were more likely to violate rent control ceilings (Ball, 2006). The 1970s were a time during which apartment owners and tenants were especially engaged in political wars over rent control as the once amateur occupations of landlord and apartment manager formalized into full-time professions (Thatcher, 2008).

By the 1980s rent controls had the consequence of disadvantaging small landlords who lost significant power over their tenants (Tucker, 1991). Such conflicts eventually led to further "professionalization" of apartment management, along with the creation of professional organizations that represented their interests, such as the National Multi-Housing Council (Thatcher, 2008).

Economic Effects

Outside the U.S., other countries have had a long history of subsidized and regulated housing. For instance, most Danish cities have rent control for unrenovated apartments built before 1991 (Lauridsen, Nannerup, & Skak, 2006). Analyses of Danish municipal data show that rent control, which "keeps rents for rented homes artificially below market equilibrium" (Lauridsen, Nannerup, & Skak, 2006, p. 64) increases the demand for rental dwellings and reduces home ownership rates.

One basic "rule" of economics that provides the basis for many criticisms of rent control is that price controls distort the housing market. Rent control, which is in essence a price control on rent, should logically lead to an undersupply of housing. Several empirical studies make this link. In one notable example, Glaesar, Gyourko, & Saks (2003) found that rent control, along with several other factors, has contrib-

uted to the rapid increase in New York City's rent prices. Fallis and Smith (1985) also found that in Toronto, where rent-controlled and market-rate apartments often co-exist, uncontrolled units are overpriced in mixed markets.

Glaeser and Luttman (2003) empirically assessed the allocation of apartments among demographic subgroups in New York, finding that 20 percent of New Yorkers were residing in "misallocated" apartments (i.e., apartments that were either too large or too small in terms of the number of rooms per person). Whether this misallocation is attributable to rent control or some other factor, such as economic inequality or the high cost of housing, for example, was not convincingly addressed.

Some have explored the topic of second-generation controls, wherein landlords are permitted to raise rents between tenants even as they are restricted from raising their current tenants' rents (Basu & Emerson, 2000). Currently, this is very common throughout the world and is roughly comparable to New York's version of rent stabilization. Basu and Emerson (2000) found these kinds of rent-stabilized apartments often have higher starting rents than their non-stabilized counterparts. Also, such arrangements incentivize landlords to select short-term tenants and provide disincentives to keep tenants. Based on their empirical analysis, the authors conclude that removing rent controls all together would likely increase efficiency in the rental market and lower rents overall.

This leads to the subject of "decontrolling" and the various ways municipalities and landlords may accomplish it. The fact that landlords benefit much more from decontrolling than do tenants (at least in the short run) makes decontrolling a politically unpopular process. Lewis and Muller (1992) have suggested that "contracting out" or allowing tenants to sell their tenancy rights to their landlords actually shifts some of the benefit of decontrolling from landlords to tenants, therefore offering a more politically acceptable means of decontrolling rental housing.

Assessing Who Wins and Who Loses

The varying theoretical perspectives on rent control raise the question of which groups gain and which lose when local governments impose, retain, or remove rent control regulations. Of course, the answer to this question depends on the perspective of the actors involved in the process and the dynamics of a given real estate market. In general terms, those most likely to benefit from the preservation of rent stabilization ordinances are the current tenants in a given neighborhood because rent controls act to depress their rents as non-regulated properties around them continue to rise.

Rent controls may also indirectly enhance a neighborhood's social capital through the disincentives for relocation produced by artificially reduced rents. Social capital is an aspect of community that is increasingly considered essential for enhancing social stability and the capacity of neighborhoods to support itself (Middleton, Murie, & Groves, 2005). Justly criticized for being an analytically "fuzzy concept," the notion of social capital as an important element for healthy communities has nevertheless

taken hold in policy and academic debates over how to revive struggling neighborhoods. At the root of the concept are issues of social trust, reciprocity, and collective action (Putnam, 2000), and among the indicators of strong social capital include stronger place attachment, higher net income, long-term residents, and homeownership (Kleinhans, Priemus, & Engbersen, 2007). As rent stabilization policies reduce the desire for tenants to relocate, even if their current housing unit is no longer "optimal" in an economic sense, rent controls may substitute for high levels of homeownership to produce the collective action associated with social capital. This may be especially true in more affluent communities with the capacity for mobilization, such as Stuy Town. Newer, market-rate tenants living in Stuy Town noted in interviews that they appreciated the sense of community they felt, especially among their old-timer neighbors. In this sense, rent control increases the value and appeal of the community, allowing landlords to charge more for the market-rate apartments than they would be able to in a less cohesive community. One resident, Carrie E., a single mother who grew up in Stuy Town and recently returned as a market-rate tenant, noted:

> I think we're sort of losing that sense of community because we have people moving in for a few years at a time; whereas it used to be that people would move in, and it was really rare for people to move out just after a few years. Obviously, things like that came up. But in my experience, people came and stayed.

On the other hand, some argue that prospective residents suffer from the imposition and retention of rental controls since the intransigence of residents benefiting from rentals that are below the market rate reduces the supply of local housing in desirable locations. Whether or not this is a problem is debatable; presumably, home ownership would lead to a similar intransigence. Further, studies of New York City indicate that barriers to increasing the housing stock are largely a result of barriers to construction rather than rent control (Glaeser, Gyourko, & Saks, 2003). As noted in the above discussion of the rent-control literature, landlords can also "lose" from the presence of rental controls. Rent controls may prevent landlords from deriving the maximum potential rents from a particular unit and may deter efforts at capital improvements. However, in the Stuy Town case, many tenants that we interviewed noted that their legally allowable rent is actually higher than the market rate due to vacancy and capital improvement increases. Further, many tenants we interviewed insisted that the so-called improvements so far have been unnecessary and costs have been inflated. In fact, it was quite common for residents to assert their suspicion that management implemented the upgrades primarily for the purpose of increasing rent and not as a response to existing residents' needs or wants.

One such improvement has been the introduction of video intercoms used to allow guests to enter the lobby. Despite the fact that many tenants do not like the intercoms and find them less convenient than the old system, management increased their rent to fund the new system. Previously, when a guest would "buzz up," the tenant's apartment phone would ring. The new video intercom requires tenants to

listen by the front door for an alert and go to their front door to buzz up guests rather than just answer the nearest telephone in the apartment, which is especially convenient for older residents. Ruth T., an old-timer who moved into Stuyvesant Town in 1947, complained:

> A lot of things . . . that they're changing I didn't like. I preferred the telephone. Now it's the intercom. I'm in the bedroom, and when that intercom comes, I don't always hear it. Then I have to walk from the bedroom to here. And sometimes people think [I'm not home], because I have a window man, and he walks away . . . [Before] we just had our regular phone. It just rang. I love that. I have the phone right there! I didn't have to get up! Now, I have to get up to find out who it is. If I know who it is, if I expect it, like with you, I don't have to run in. I didn't like that [change].

According to existing law, landlords may increase rents by 1/40th of the cost of allowable renovations so that after forty months any renovations have been funded even though the rent increase remains in place. The 2011 rent stabilization laws further strengthen tenants' rights in this regard, allowing landlords to increase rent by only 1/60th of the cost of allowable renovations.

Critique of Current Literature

Empirical studies that try to assess the impact of various rent control regimes on the quality, quantity, and prices of housing are fraught with difficulty (see Arnott, 1995). Economists have a notorious and near universal opposition to rent control because of the market distortions it can create. For instance, one poll showed that 93 percent of U.S. economists agreed that "a ceiling on rents reduces the quantity and quality of housing available" (Alson, Kearl, & Vaughan, 1992). Yet this view seems to be based on the strictest form of rent control, which applies to a small minority of rent-controlled housing. Much more common are second-generation rent control and rent stabilization laws, which have eliminated many of the problems of the first-generation controls (Arnott, 1995).

The ideological component of the debate on rent controls cannot be ignored in assessing the research. Rent control represents government intervention in the rental market and stands in opposition to the theories of many mainstream economists, especially advocates of free-market policies for urban redevelopment. Yet the concept of housing as a human right is lost when such economic imperatives are privileged. As successive generations of "right to the city" advocates have argued, housing is not an interchangeable widget; homes are places where people raise their families, fostering a more inclusive and open urban environment (Brown & Kristiansen, 2009; Lefebvre, 1996). Though missing in many econometric models, neighborhood stability is of great value to residents but is threatened when cities adopt privatization policies (Smith, 1996). In general, the research on rent control has focused on economic effects, often overlooking the social impact of rent control on community stability, neighbor social relations, and residents' quality of life.

Figure 30.1. Stuyvesant Town Area Map.
Source: Detail of Manhattan from NYC Map (nyc.gov/citymap).

Arnott (1995) suggests that one way to get around the lack of sufficient data in assessing the success of rent control is to conduct case studies. Stuy Town represents one such case (see figure 30.1 for a Stuyvesant Town area map). Its success should be assessed based on the intended goals for the development, which were to transform a slum into safe and stable housing for middle-class New Yorkers, including veterans returning from the war. Given that rent stabilization came under threat in the late twentieth century, the case of Stuy Town also serves to highlight the deepening encroachment of an ideology that assumes housing developments are simply a source for profits, rather than a site for community.

STUY TOWN: A CASE STUDY OF RENT CONTROL AND DESTABILIZATION IN NEW YORK CITY

Stuy Town and Peter Cooper Village opened in 1947 to house the middle class, especially the families of World War II veterans. It was built, at least in part, as a response to the housing crisis that started during the Depression and intensified by the Second World War. During the war, New York City began implementing the Emergency Tenant Protection Act, also known as rent control, to prevent landlords from profiteering off the economic boom caused by the war and to provide safe, stable and affordable housing to veterans returning home and starting families.

Figure 30.2. Aerial image—Stuyvesant Town and Peter Cooper Village, 1954.
Source: Detail of aerial photo altered from NYC Map (nyc.gov/citymap).

Many city officials considered the future site of Stuy Town to be ideal for a slum clearance project. Mayor LaGuardia asked Robert Moses, a New York state and municipal official who was instrumental in guiding the city's mid-century public works, to devise a way to persuade insurance companies to invest in middle-income housing and slum clearance in Manhattan (Moses, 1943). As a result, the state passed in 1942 the Redevelopment Companies Law that permitted insurance companies to receive tax abatement and eminent domain rights to facilitate investment in middle-income housing. The bill was passed after the city added the amendments that MetLife specifically requested with the Stuyvesant Town project in mind (Moses, 1943).

On April 18, 1943, this powerful planning coalition first made public its plans for Stuyvesant Town (Schwartz, 1993), which called for the construction of apartment buildings on an eighteen-block area that would house twenty-four thousand middle-income residents (see figure 30.2 for a 1954 Stuyvesant Town aerial photo). MetLife was awarded eminent domain over the soon-to-be-demolished Gas House District and was granted a twenty-five-year tax abatement to expedite construction of the development. Moses considered it necessary to award considerable latitude to MetLife to overcome corporation leaders' historic reluctance to invest in New York's housing market. However, many New York residents were vocal in their concerns about the government overreaching in its encouragement of private sector investment in the city's medium-income housing. New York citizens and planners alike were also worried about the potential lack of public facilities and schools that the city and investors

would provide as part of the development. Further, many New Yorkers were critical of the fact that MetLife would have the power to deny the public of access to the site.

Anti-black racial discrimination policies were another point of contention surrounding the origin of Stuy Town. MetLife made it clear from the start that management did not intend to accept applications from African Americans. Though the Fair Housing Act was not enacted until 1968, existing fair housing policies protect African Americans from discrimination in gaining access to public housing projects. However, despite the public subsidization of MetLife's development, Stuy Town had the status of a private project, which granted management far more freedom in choosing the racial composition of residents and discriminating against nonwhites—freedom that Robert Moses supported vigorously.

Finally, many of the eleven thousand residents living in or near the site were concerned about displacement and plans for relocation. In a letter to the editor on June 3, 1943, Robert Moses indicated that MetLife and the Stuyvesant Town Corporation would relocate the residents at no cost to the city. Local residents formed the Stuyvesant Tenants League, a branch of the United Tenants' League, to advocate for residents, coordinate social services, and provide support for the soon-to-be-evicted tenants (Schwartz, 1993). Even so, the seemingly inevitable destruction of the Gas House District meant that resistance to displacement was muted.

The plan for Stuy Town went to the Board of Estimates, a city panel that made land use decisions, with members approving the plan within just a few weeks. Such hasty consideration meant there was little opportunity for the details to be carefully considered or for the public to debate either the design or the redevelopment strategy. Exacerbating the narrow window for public participation was the fact that three of the most powerful men in New York City at the time, LaGuardia, Moses, and MetLife chairman Frederick Ecker, were all strong Stuy Town champions. Against this triumvirate of city power and amidst the backdrop of planning rhetoric proclaiming the creation of a better post-war New York, the public stood little chance of successfully opposing the plans for Stuy Town. In the end, Stuy Town's plans were approved over the objection of two members of the Board who dissented because they objected to its racially discriminatory policies. The plans for Stuy Town's whites-only development would soon become a reality.

The Community-Building Years

Though white and segregated, Stuy Town did boast ethnic diversity in its mix of Jews, Catholics, and Protestants, which distinguished it from many of New York's white ethnic enclaves that were dominated by people of one nationality or religion. Still, in the post-war years, this relative ethnic integration did not compensate for the racial discrimination faced by African Americans who also wanted access to these new apartments. In 1948, with the support of some community members, three African American World War II veterans brought a lawsuit against Stuy Town, hoping for permission to apply to be tenants. Ultimately, the courts dismissed their

complaints and upheld the right of MetLife to engage in racial discrimination (Biondi, 2003).

This court ruling did not deter residents from organizing to challenge the whites-only policy. In 1948, approximately 1,800 residents formed the group "Tenants Committee to End Discrimination," which conducted surveys showing that two-thirds of Stuy Town tenants opposed Met Life's racially exclusionary policy (Fox, 2006). In fact, one tenant, a college professor, even invited an African American family to move into his apartment to protest the discrimination. Met Life was charged with racial discrimination for attempting to evict this family and thirty-six other Stuy Town residents who were members of the tenants committee (*New York Times*, 1952). Soon after, several of these tenants moved out of the development in protest. According to reports in the *New York Times*, scores of organizations and thousands of individuals became more vocal in their opposition to Stuy Town's practice of racial discrimination, and these voices were becoming difficult to ignore (Martin, 2000). Nineteen members of the tenants group continued their campaign to end discrimination by taking their case to court and then winning the lawsuit. Finally, in 1952, Stuy Town management granted its first lease to an African American family.

Because Stuy Town's original residents were exclusively veterans and their wives, the effects of the "baby boom," such as the increased birth rate, were magnified in Stuy Town. In a decade, the population swelled from twenty-five thousand to thirty-five thousand and Stuy Town became known as "the rabbit farm" (Martin, 2000), with thousands of families raising children in the "accidental utopia" that was Stuy Town (Demas, 2006). The safety net of affordable, stable, controlled rent ensured that families could stay if they chose, which translated into tenants' longer lengths of residence, strong social ties, and a sense of community identity and attachment. With residents firmly rooted, prospective tenants began to request slots on a waiting list on which they would linger for years until a vacancy occurred.

For the next several decades Stuy Town remained largely unchanged (Kinetz, 2001). Such residential stability is indicative of economists' standard critique of rent controls: they distort the market because aging residents have no incentive to downsize into more "rational" or appropriate housing stock. However, it is hard to deny that Stuy Town's residential stability protected a vibrant moderate-income community within one of New York's most expensive areas, creating a sense of place in the midst of a rapidly changing late-twentieth-century real estate market in Manhattan. Indeed, in the broader context of New York's housing market, Stuy Town functioned as a stable northern border against the nearby East Village gentrification of the 1980s (Smith, 1996).

The Capital Improvement Years: Upscale Stuy Town

Over the years, the hard rules of rent control devolved into the softer system of rent stabilization. In the 1990s, MetLife enacted a series of major capital improvements, including rewiring the electrical system, replacing windows throughout the buildings, and creating amenities such as gyms and cafes. (See Figure 30.3 for a map

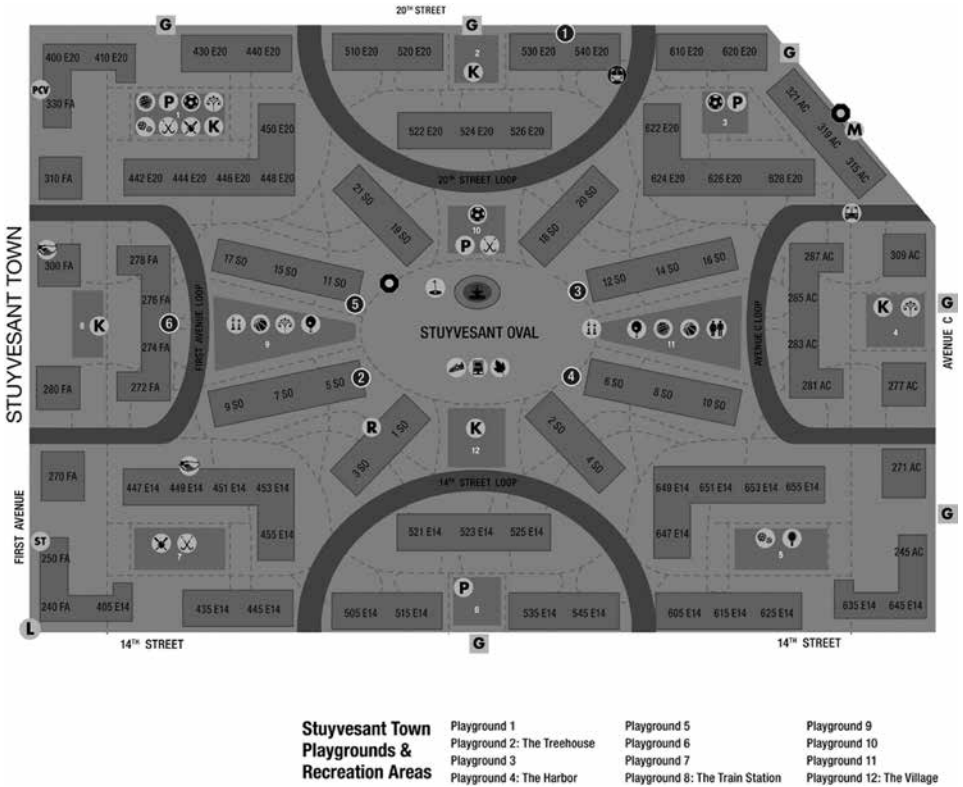

Figure 30.3. Stuyvesant Town Amenities.

Source: Adapted from Peter Cooper Village/Stuyvesant Town Map (https://resident.stuytown.com/Websites/Common/Files/files/ST%20Map.pdf).

with a list of amenities). These were large-scale projects that were costly enough to allow MetLife to pass on some of the expense to tenants in the form of rent increases. Such capital improvements continue, with mixed reviews among tenants (Kennedy, 1991). In general, our interviews revealed that while residents appreciate some of the benefits of some of the improvements, many complain that upgrades are excessive and exclusionary, with additions such as wi-fi availability designed to attract young people rather improve the lives of older, current residents. In fact, many long-standing residents admitted their suspicion that lavish upgrades are actually a management tactic to eject rent-stabilized tenants and convert their apartments to market rate. Some evidence supports their fears in that the New York state legislature implemented mechanisms allowing landlords to exempt rental units from rent regulations in the 1990s. One of these mechanisms, known as "luxury decontrol," enables landlords to remove vacant rental units from rent control status once rents reach $2,000 per month. This can be reached by a combination of percentage rental increases for vacant units, plus an increase for improvements made to the property (Brescia, 2010).

Selling Out: The Transition to Market Rate

In the late 1990s, Stuy Town's reputation as a modest community for working families was about to change. In 1997, New York passed a law stating that once the rent on an apartment exceeds $2,000, it must become deregulated. At that point, a landlord may ask any price for the apartment that the market will bear. Around 2000, some of the rent-stabilized apartments in Stuy Town hit this threshold, and MetLife converted them to market rate. In 2001, MetLife made an attempt to expedite such conversions by initiating a $50 million project to improve the grounds, including upgrading the playgrounds, lighting, and landscaping. MetLife officials knew that the more the property improved, the faster rents could be increased, and the sooner management could designate apartments as market rate.

Changes in the Stuy Town waiting list reflected these improvements, rent increases, and conversions to market rate units. In earlier years, rental applicants waited several years for a rent-stabilized apartment. For instance, in 1991, the wait for the Stuy Town segment of the complex was five years and more than ten years for the more spacious Peter Cooper Village (Oser, 2001). With the conversion to market rate, fewer rent-stabilized apartments were available, and the waiting list for rent-stabilized apartments was terminated.

The formalization of Stuy Town's transformation was imminent. The property featured a plaque honoring a MetLife chairman, inscribed with the quotation "that families of moderate means might live in health, comfort and dignity in park-like communities and that a pattern might be set of private enterprise productively devoted to public service" (Demas, 2006). In 2002, MetLife engaged in major renovations and introduced a tenants' "concierge service" to better compete in New York's luxury apartment market. Around the same time, management removed the

plaque, placing it in the archives, symbolizing the end of an era for Stuy Town and its residents.

A comparison of Stuy Town's populations in 1950 and in 2000 shows that much had changed even before the transition to market rate (Beveridge, 2006). In terms of ethnicity, Stuy Town has only changed from completely white to mostly white. As for social class, as indicated by residents' occupations, residents are far more professional in contemporary Stuy Town than they were after World War II. Perhaps most interesting is the change in family composition. The young married couples with children from the 1950s have become Stuy Town elderly residents of today. Those who moved away or died were largely replaced by unmarried singles and some young families, many of whom are the adult children of original residents. When one walks around the meandering paths that weave through Stuy Town, it is not uncommon to meet adults eager to share the fact that they grew up there and proudly raise their own children in the development.

The 2006 Sale of the Properties

In the fall of 2006 MetLife announced that it was placing Stuy Town (including Peter Cooper Village) on the auction block (Bagli, 2006a). Many residents were troubled when they heard news. Daniel R. Garodnick, a member of New York City Council who was raised in Peter Cooper Village and has continued to live there with his wife and son, was incensed about the sale. According to his website, Garodnick has "established himself as a leader in the fight for affordable housing, spearheading the $4.5 billion tenant-backed bid for the purchase of Stuyvesant Town/Peter Cooper Village." He sought to place a bid on the two communities by organizing fellow tenants and investors.

Initially, MetLife considered this group to be an "unqualified bidder" and thus not eligible to be considered for a real estate deal. However, elected officials pressured the company to take the bid seriously, and MetLife provided the group with "bidding books" that contain information about the potential worth of the property. In the end, Tishman-Speyer, "one of the leading owners, developers, operators, and managers of first-class real estate in the world" (Finn, 2006), outbid the tenants' group and took over the two complexes, paying $5.4 billion for the property and making this transaction the largest sale of a single property in U.S. history. The price averaged out to over $450,000 per unit, and rent rolls only covered 58 percent of the monthly mortgage payments on the property, leaving Stuy Town's middle-class, rent-stabilized tenants justifiably concerned. The selling price left little mystery about what the new owners planned to do with the property. The only way for Tishman-Speyer to feasibly make a profit on the deal was to fully convert the housing development to a luxury apartment complex. During the period of time that it owned the property, Tishman-Speyer was highly motivated to continue what MetLife initiated: expelling rent-stabilized tenants and converting their apartments to "luxury" market-rate units as quickly as possible.

However, two important events interfered with the steady march of Stuy Town's market rate period, and these events ushered in a new period of uncertainty. First, the housing crisis of 2008 to 2009 caused the market value of the property to drop significantly. The second landmark event was the 2009 *Roberts* decision in which the New York Court of Appeals ruled that the owners of Stuyvesant Town had improperly deregulated apartments (and increased rents) while also receiving a J-51 tax abatement, which requires landlords to stabilize rents. By the end of 2009, it was clear that Tishman-Speyer would not be able to continue to make the monthly payments on the property and would have to relinquish the property to a special servicer in order to avoid foreclosure. Though this move created significant instability and uncertainty for residents, in the future it may open doors for further democratization of this and similar communities. In communities across Manhattan, the *Roberts* decision has motivated residents to organize and advocate for ownership through a co-op or condo conversion, with tenants acquiring apartments at rates below the market value.

CONCLUSION

The story of Stuy Town is not merely one of a large-scale urban housing development. The La Guardia administration originally conceived of the project to accommodate twenty-four thousand middle-income tenants in post-war New York. However, Stuy Town has come to represent an early example of publicly subsidized private development, and its history showcases the conflicts that arise when citizens seek rent-controlled housing and developers seek higher profits. In essence, Stuy Town's history is bound up with that of mid- to late-twentieth-century capitalist development in New York City and elsewhere, wherein housing, once viewed as a social right, has been narrowly redefined in terms of profit.

Stuy Town could not have been created without the partnership between the City of New York and the MetLife Insurance Company. In return for generous twenty-five-year tax abatements, powers of eminent domain, and the architectural services of Robert Moses's planners, MetLife created a large-scale housing development serving whites with moderate incomes. Stuy Town was housing reserved for families with moderate incomes because of the strong rent controls made possible by the Emergency War Tenant Protection Act. Rent-control legislation in New York City changed over the coming decades, but by the 1990s many of the rental units in Stuy Town were still covered by some form of stabilization, hence generating less revenue for the landlords than would otherwise have been possible, given the demand for housing in Manhattan. Nevertheless, Stuy Town provided a sense of place and forum for an increasingly diverse community, aspects of urban housing which are commonly overlooked in the heated debates over the economic merits of rent-control legislation.

Economic imperatives over the built environment often trump social imperatives in the context of the neoliberal development that characterized cities in the late

twentieth century. As others have argued (Weber, 2002), neoliberal administrations denigrate collective consumption and institutions, favoring instead the reification of free market principles that seek only the highest possible rates of return for every parcel of land in the built environment. Under such conditions, the publicly subsidized origins of developments like Stuy Town are conveniently forgotten when developers seek to dispose of rent-stabilized properties in favor of market-rate rentals. However, these goals are not uncontested, and the community of Stuyvesant Town has responded to the potential sale of their buildings with a level of mobilization unmatched by the community members dispossessed by the construction of Stuy Town in the 1940s (Brescia, 2010).

Stuy Town's social dimension, therefore, becomes as important a component to the story of urban rent controls as economic dimensions of supply and demand are. As the processes of neoliberal development continue to deepen in the built environment, citizens are attempting to subvert or supplant plans to convert affordable housing into market-rate housing. At the same time, this may be symptomatic of the unique composition of residents who currently reside in Stuy Town. Rather than the poor and disorganized communities that were cleared from the Gas House District to make way for Stuy Town, today's residents are more diverse, well educated, politically connected, and informed about the threats to their community. Thus, context matters in debates over affordable housing; in Manhattan's Stuy Town, the vulnerable were not the poor or disenfranchised. Yet Manhattan should not be a city reserved for the rich. Middle-class families contribute to the functioning of New York City businesses, institutions, and communities, but increasingly the city has become inhospitable and out of their reach. Future research on rent controls should pay closer attention to the complex social dynamics of communities undergoing challenges related to affordable housing, as these demographics doubtlessly affect the outcomes of conflicts between tenants and landlords.

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31

The Epilogue

Confronting the Dilemmas of Twenty-First-Century Urban Living in Global Contexts

Carol Camp Yeakey, Vetta L. Sanders Thompson, and Anjanette Wells

For all the allure of speciously stress-free suburbs, for all the grinding of city life, cities endure. And when all those diverse energies are harnessed, and those choices, private and public, cohere, and all the bargains made in a million ways every day hold up, then a city flourishes and is the most stimulating center for life, and the most previous artifact, a culture can create. Think of great cities large and small (size, as with any work of art, does not necessarily determine value) and, in addition to nodes of government, commerce, law, hospitals, libraries, and newspapers will come to mind, as will restaurants and theaters and houses of worship and museums and opera houses and galleries and universities. And so will stadia and arenas and parks. In short, one finds not simply commerce but culture, not simply work but leisure, not only negotium but otium, not simply that which ennobles but also that which perfects us. Such has forever been the ultimate purpose of a city, to mirror our higher state, not simply to shelter us from wind and rain. As with leisure, so with the city: It is the setting to make us not the best that Nature can make us, but to manifest the best we, humankind, adding Art to Nature, can make us.

A. Bartlett Giamatti (1989, p. 75)

Dull inert cities, it is true, do contain seeds of their own destruction and little else. But lively, diverse, intense cities contain the seeds of their own regeneration, with energy enough to carry over for problem sand needs outside themselves.

Jane Jacobs (1961, p. 57)

The next 2 billion people will live in cities, so we must plan for them now.

United Nations Population Fund (2011)

The world is for the first time more urban than it is rural (Palen, 2012; Phillips, 2012; UNFPA, 2007), and while *Urban Ills* has focused on the challenges of city life, there are many positive consequences of this change. For many, urban living is associated with access to social, political, economic, and cultural opportunities. Globally, urban areas are the vibrant, innovative centers that attract both those with access to resources, as well as those in need of resources, offering opportunities for commerce and technology that tend to generate jobs and income. The cultural benefits of urban centers include the intellectual and cultural resources available, such as library systems, educational and research institutions that support intellectual development, industries that drive and support the scientific and technological advances that fuel economic growth and development, as well as cultural museums and centers for the arts and entertainment. The population density associated with urban centers means that if managed well they can deliver education, health care and other services more efficiently than rural and smaller suburban areas (UNFPA, 2007). And, in a world where global environmental concerns (i.e., climate change, toxic pollution, hurricanes, frequent floods and landslides, etc.) are mounting ("Air quality," 2011; Satterthwaite, 2008; "Urban Poverty," 2010), it is important to remember that housing more people in densely populated spaces, though challenging, will facilitate efficient travel and alleviate some of the pressure on natural habitats that we will need to preserve into the future (UNFPA, 2011).

It is anticipated that by 2050, as many as two of three individuals around the world will live in an urban area (Palen, 2012; Phillips, 2010; UNFPA, 2011). Our challenge as the world urbanizes is to capitalize on and manage the possibilities that urbanization offers (Palen, 2012; Phillips, 2012; UNFPA, 2007). Despite calls to recognize and plan for the effects of increased globalization and urbanization, we have failed to consistently unravel and address even the most immediate issues, including inequality, hunger, homelessness, crowding, lifestyle changes, disease, security concerns, illiteracy, and insufficient social services (Macionis, 2012). The impact of not resolving these challenges go beyond geographical borders. For example, the significant obstacles facing China as she transforms her cities is critical to not only the future prosperity of China, but to the rest of the world, as well (Paulson, 2012; Makinen, 2013). The greatest of these needs is acknowledging the interconnectedness of housing, education, transportation, employment, safety, and health needs for diverse populations. While addressing the foregoing needs are necessary, they are insufficient without addressing the crumbling infrastructure needs of cities, which impact both the urban poor as well as higher-income urban populations in both developed and developing nations (Paulson, 2012; UNFPA, 2007).

The slow economic recovery following the "Great Recession" and ensuing global financial crises have impacted the ability of cities to address the needs and concerns of their most vulnerable residents. With many of the poor migrating to urban areas (Keller, 2012; UNFPA, 2007), poverty is now growing faster in urban than in rural areas (Kneebone & Garr, 2010; UNFPA, 2007). In the United States alone, suburbs are now home to the largest and fastest growing poor population in the United States

(Kneebone & Garr 2010). Even worse, campus food pantries for poor students are now becoming less of a novelty as suburban America begins to confront the poverty now relocated to America's suburbs (Garr & Kneebone, 2010). With high levels of inequality and disparity and the lingering effect of the economic crises, it is unclear whether sufficient political will and resources will be made available to address present and future challenges. Reflecting on where we have been allows us to learn, correct and plan for the future.

While we typically focus on our largest cities, population trends indicate that most of the urban growth in the future will take place in primate cities in the developing third world (Palen, 2012) as well as in smaller cities and towns (UNFPA, 2007). Of great concern is whether the political and managerial leaders of these emerging urban centers will have the experience and resources to respond to this growth and whether there is a sufficient evidence base to suggest what will work to assure equitable distribution of resources to meet the needs of these diverse communities.

This collection of essays in *Urban Ills* suggests four major areas of focus as nations around the globe move toward confronting the challenges of greater urbanization.

1. De-concentration of poverty in urban centers and within specific areas of urban centers.
2. Access to adequate sanitation, housing, food, health care and employment.
3. Access to high-quality education, particularly for poor, ethnic and racial minorities and youth.
4. Reduction of inequalities attributed to discrimination (either historic or contemporary), and the marginalization and isolation of populations, due to race/ethnicity, gender, religion, culture, or class biases.

Of great concern is the ability to plan and design spaces that accommodate the needs of the poor, the middle class, as well as wealthier members of urban communities. Approximately one billion people live in urban slums, which are typically overcrowded, with inadequate housing, pollution and danger due to crime, gangs, or rape, to name a few. In developing countries, the lack of basic services such as clean water, sanitation and adequate roads (UNFPA, 2007b) only compound the aforementioned challenges. Spatial concerns include maintenance of water and sanitation systems in established cities and the development of adequate systems in the fast-growing urban communities of developing countries to assure that the poor live in safe and sanitary environments. In addition to infrastructure needs, adequate housing will be crucial. In less-developed countries, individuals migrating from rural to urban areas typically have limited resources and often end up in slums with minimal access to sanitation, health care and education ("Population distribution," 2011). Without adequate planning for water, sanitation, housing and management of environmental exposures associated with urban living and dense populations (Alkali, 2005), health becomes a concern. While the concentration of the health-care workforce, institutions and technology in urban areas suggests the opportunity to

improve health as the world urbanizes, the gains will be compromised to the extent that we fail to manage sanitation and housing in slums and poorer communities. Most importantly, well-intentioned government housing and economic policies and interventions must not lead to or exacerbate the concentration of poverty, sexism and oppression in certain regions whether the defining issue is race/ethnicity, religion, culture, or class. Urban renewal strategies of the future, such as mixed-income housing and place-based development, must avoid the gentrification of urban spaces and the mere shifting of poor from one defined region to another, as well as increased social isolation of poor and minority populations.

Numerous other challenges exist as urbanization proceeds. Many individuals migrate to urban areas in search of jobs and economic opportunity, but it is not clear that cities in developed or developing countries can absorb the demand for employment (Makinen 2013; Palen, 2012; UNFPA, 2007; Kasarda, 1985) causing a theoretical 'mismatch.' According to the 'mismatch' hypothesis (Kasarda, 1985), there is a disconnect between central city residents' job skills and the type of information-age jobs being created in the cities. Excluding white collar jobs which require higher education, reports suggest that even with high unemployment, skilled manufacturing jobs go unfilled (Giegerich, 2012; Whoriskey, 2012). As automation has transformed factories and altered the skills needed to operate and maintain factory equipment, laid-off and underemployed workers, who may be familiar with the old-fashioned presses and lathes, are often unqualified to run the new equipment, pointing to a mounting skills gap (Belz, 2012). Compounding the problem is a demographic shift. At some factories, much of the workforce consists of baby boomers nearing retirement. Younger workers are avoiding the manufacturing sector because of the volatility and stigma of factory work, as well as perceptions that U.S. manufacturing is a 'dying industry' (Whoriskey, 2012). Much of the demand for skilled workers in the United States arises because automated factories demand workers who can operate, program and maintain the new computerized equipment. The new manufacturing jobs require more than a high school education and require job-specific training, resulting in a two-year (beyond high school) mechatronics degree (Whoriskey, 2012). As opposed to achieving the American Dream, for too many, getting ahead in life is now defined as not falling behind (Brownstein, 2012). "Holding on is . . . the reality of the future . . . " (Brownstein, 2012, p. 2).

Prior to the world's current economic woes, deindustrialization strained the capacity of cities to provide employment for less well-educated and low-skill residents. In the midst of our most recent global economic downturn, urban communities in industrialized nations have failed to generate sufficient jobs. Unemployment rates remain high despite economic recovery, with the International Monetary Fund forecasting high unemployment for years to come (IMF, 2011). Thus, it is imperative that we put new energy into understanding not only the factors affecting urban economic growth, but also the appropriate level of supports to achieve a high quality of life for the widest range of the diverse populations occupying global urban centers in varied economic environments.

Education and empowerment for women and the growing youth population of cities are critical (UNFPA, 2011, p. 3). Increased education, economic and health care access will contribute to reproductive health and family planning, reducing maternal mortality rates and will also assist in efforts to stem poverty (King & Hill, 1993). Educational resources must, however, be designed to meet the diverse needs of communities composed of individuals of different religious, linguistic, cultural and economic backgrounds and must be of high quality. Despite the recognition of the role of education in addressing poverty, health and quality of life, educational disparities among lower-income and ethnic-minority men, women and youth persist in the most industrialized and urban nations in the world (Dollar, 2007; McClure, 2011).

Income has always shaped academic success, and the influence of income transference from parents, is growing in importance (OECD, 2011; Reardon, 2012). Noted Stanford University sociologist Sean Reardon's recent research has noted that the achievement scores of high- and low-income students has grown by 40 percent, even as the difference between Blacks and Whites has narrowed. While race once predicted scores more than class, the opposite now holds. While racial gaps in achievement are large in the United States, income gaps have become larger (Deparle, 2012). A generation ago, families at the ninetieth percentile had five times the income of those at the tenth percentile. Now, such families have ten times as much income (Deparle, 2012). It is projected that affluent families have tripled the amount they outspend low-income families in their investment in education and enrichment activities. And as the payoff for education has grown, as previous chapters have shown, college graduates have greatly widened their earnings lead. As Professor Reardon has noted, "It is becoming increasingly unlikely that a low income student, no matter how intrinsically bright, moves up the socioeconomic ladder" (as quoted in Deparle, 2012). As colleges and universities fail to lure the talented poor, the long-term consequences of missed career opportunities and social class mobility cannot be overstated (Hoxby & Avery, 2013). While the poor and middle-class struggle with competition for low-wage jobs, with higher costs of living (D'Innocenzio & Rugaber, 2013), they remain pessimistic about their future career prospects, job security and their finances (Associated Press & National Opinion Research Center, 2013).

Issues of educational disadvantage, underachievement, and resultant social immobility have led to a permanent underclass, an underclass that challenges not only cities but the economic advance of nation states across the globe. Education, that is advanced schooling, is a social welfare issue, part of any society's social safety net. What is required is political will and resources to identify what combination of strategies and resources work and to deplore them systematically and efficiently to support the diverse educational needs of underclass populations in developed and emerging economies facing similar population diversity and educational disadvantage.

As the United States has found, there are significant collateral costs to mounting social inequality and economic immobility, including but not limited to an unprecedented incarceration rate and its accompanying social ills: illiteracy, the hidden

'underground' labor market, the intergenerational impact of incarceration on children, families and communities, and the permanent loss of real income to the nation's gross domestic product (PEW Charitable Trusts, 2010). Collateral damage done to impoverished, high-crime neighborhoods in the United States has caused many neighborhoods to be known by the dangers they pose to innocent women, children and other vulnerable individuals. Death Corner (Sampson, 2012) and the Devil's Playground (Yeakey, 2011) in Chicago, Illinois, are among the infamous names of far too many urban neighborhoods plagued by the intended and unintended consequences of decades of social and economic inequality and immobility and the lack of attention brought to resolve these embedded issues.

Public officials entrusted with the safety and care of their citizenry must have the financial support, training, skills and resources to identify the needs, facilitate communication, and to implement and evaluate activities designed to address the social issues and conditions which encompass the futures of far too many underclass populations (Boushey & Hersh, 2012; UNFPA, 2007). As the economists in previous pages related, effective and inclusive governance for the common good ensures the political stability necessary for higher productivity and economic growth (Boushey & Hersh, 2012). These skills will assist public officials in supporting and maintaining social capital, an important component of successful urban living (Sampson, 2012; Almedon, 2005; Sampson, Raudenbusch, & Earls, 1997; Sampson, Morenoff, & Gannon-Rowley, 2002). Those living in areas with higher levels of collective efficacy, sense of community and informal control have lower rates of mortality and violence with more promising educational and social outcomes among youth. Social capital, critical to the development of community resources, can wane in stressful and high-need environments (Almedon, 2005; Sampson, Morenoff, & Gannon-Rowley, 2002).

Also of great concern is retaining respect for the ideas, opinions and perspectives of diverse members of these communities (Schulz, Freudenberg, & Daniels, 2006). Poor neighborhoods and communities have been mobilizing for centuries to address the inequities that they face and that threaten their quality of life (Sampson 2012; UNFPA 2007; Schulz, Freudenberg, & Daniels, 2006). Planning for urban communities that does not empower community members and their neighborhoods is unlikely to yield the outcomes desired (Schultz, Freudenberg, & Daniels, 2006). Some of the most urbanized countries in the world offer the opportunity to understand what has worked and what has not and should inspire the world citizenry to innovate and move toward healthier, more equitable, social and economic outcomes for all ("Employed," 2010; "United Nations," 2008; Yuasa, 2009).

What are the most promising means of tackling the question of inequality and uneven success and mobility among the social classes in our urbanized societies? What measures can be taken for those who live on the margins of life? (Yeakey, 2012; OECD, 2011). First and foremost, providing free and accessible and high quality public services such as education, health care and family care are critical. Second, providing job skills, training and retraining for the high tech jobs in our

competitive global economy are basic requirements. Tied to this is the creation of more and better jobs which lead to career prospects to enable persons to escape poverty. What is required is school to work transition that provides incentives for both workers and employers. All of the foregoing requires an investment in human capital, in human resources, from early childhood through compulsory schooling. Finally, the issue of redistributive policies must be addressed directly. When the growing share of incomes go to the top earners, it should come as no surprise, that there is growing tension, a politics of resentment, among the social classes (Yeakey, 2012).

Challenges of the new economy and increasing urbanization require that nations address the issue of redistributive policies to avoid the growing tension between society's 'haves' and 'have nots,' a tension which has created discord among social classes across societies. Tied to this is the need to strengthen, rather than eliminate, the social welfare safety net for those who cannot provide for themselves, for those who find themselves crowding into urban centers for opportunity, work and hope for a better future. However, the news is as pervasive as it is disheartening amid reports which show that growing economic disparities are tied to life span, that is, shorter life expectancies among the poor, yet longer life expectancies among the wealthy (Martin, 2013; Fletcher, 2013).

Lessons learned from urban revitalization and gentrification efforts that have displaced individuals in the name of progress, pushing children and families further into economic ruin and social deprivation, need not be repeated (Yeakey, 2011). We now know that urban revitalization does not 'lift all boats' and comes with dire human costs. The planning of urban spaces must begin to consider community needs and interests, broadly defined, in addition to the needs and preferences of monied individuals, for the collective good (Sampson 2013; Yeakey, 2011; Jacobs, 1961; Duhl & Sanchez, 1999). Where more recent revitalized urban communities in cities around the globe are successful for the poor and the rich alike, such communities provide new perspectives to assist in supporting and strengthening older and newer urban neighborhoods and the mounting challenges they face in the twenty-first century.

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Contributors

Editors:	Carol Camp Yeakey	Washington University in St. Louis
	Vetta L. Sanders Thompson	Washington University in St. Louis
	Anjanette Wells	Washington University in St. Louis

Daryll Archibald	University of St. Andrews (Scotland)
Tim A. Bruckner	University of California at Irvine
Sheretta T. Butler-Barnes	Washington University in St. Louis
Nicholas Buys	Griffiths University (Australia)
Elián P. Cabrera-Nguyen	Washington University in St. Louis
Jennifer P. Doyle	University of Central Lancashire (United Kingdom)
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Robert J. Sampson	Harvard University

Lonnie R. Snowden	University of California at Berkeley
Jing Sun	Griffiths University (Australia)
Vetta L. Sanders Thompson	Washington University in St. Louis
Xinchao Wang	Peking University (China)
Anjanette Wells	Washington University in St. Louis
Rachael A. Woldoff	West Virginia University
Carol Camp Yeakey	Washington University in St. Louis
Marc A. Zimmerman	University of Michigan