**Journal of Qualitative Criminal Justice & Criminology • 2020 | Volume
8, Issue 4**

**Community-Based
Participatory Research:
How Residents of a Small
Low-Income Racially
Homogenous
Disadvantaged
Neighborhood Perceive the
Effects of Poverty Stigma,
Community Disorder, &
Feelings of Unsafety on
Health**

Stan Korotchenko¹, Kim M. Anderson¹

¹University of Central Florida

Published on: Aug 01, 2020

DOI: 10.21428/88de04a1.ba9d01ad

License: [Creative Commons Attribution 4.0 International License \(CC-BY 4.0\)](https://creativecommons.org/licenses/by/4.0/)

ABSTRACT

Although research indicates that social determinants impact minority health, there remains a dearth of knowledge on how economically disadvantaged communities perceive the effects of poverty stigmatization, community disorder, and feelings of unsafety on their health status. This qualitative study used community-based participatory research methods to explore how minority residents (n=23) from an urban neighborhood of concentrated poverty perceived the impact of residential and environmental factors on their health. Thematic analysis highlighted how the combination of high crime rates and community disorder negatively affected residents' ability to maintain a healthy lifestyle due to increased levels of stress and decreased access to health resources. Additionally, perceptions of stigmatization and feelings of unsafety adversely impacted levels of community connectedness and collective efficacy and prevented efforts to improve their individual and neighborhood health conditions.

Introduction

Scholars, practitioners, and policymakers recognize that factors influencing the health status of economically disadvantaged minority communities span beyond the impact of healthcare systems. Studies on social determinants of health have found that socioeconomic status and race/ethnicity are two of the main factors associated with health disparities in the United States (Braveman & Gottlieb, 2014; Rust, 2017). Social determinants of health include “economic stability, neighborhood and physical environment, education, food, community and social context, and the health care system” (Artiga & Hinton, 2018, p. 1). Communities of disadvantage often are faced with more crime, a lack of access to safe places to exercise, have limited access to health care, or even healthy food choices, and experience more adverse health outcomes (Ousey, 2017). Although a significant amount of research has been done on the social determinants of health (Braveman & Gottlieb, 2014; Marmot, Friel, Bell, Houweling, & Taylor, 2008; Raphael, 2006; Wilkinson & Marmot, 2003), it lacks inquiry into the effects of poverty stigma, community disorder, and feelings of unsafety on health outcomes, particularly from the perspectives of those experiencing such social problems first-hand.

This qualitative study employs community-based participatory research to better understand the lived experiences of residents from “The Vicinity,” a population of 4,500 residing in approximately 1.3 square miles within an urban area in central Florida (U.S. Census Bureau, 2017). Established in the 1880s, The Vicinity is the oldest concentrated African American population in the city. It consists of three neighborhoods that possess similar characteristics: most of the residents are minority low-income families with limited access to education, employment, and healthcare. The median household income is approximately \$15,000, and the child poverty rate is 73%. The crime index of The Vicinity is more than twice as high as the crime index of the city (U.S. Census Bureau, 2017). The community is

isolated from the rest of the city by highways and has limited access to grocery stores, restaurants, and recreational spaces. The Vicinity has experienced many of the same issues as other urban African American communities, such as disenfranchisement, disruption, and violence, particularly drug distribution and street violence (U.S Census Bureau, 2017).

The main purpose of this study is to understand how residents view the effects of poverty stigma, community disorder, and feelings of unsafety on their health status. We are hopeful that we will bring attention to the scientific community, as well as public administrators, the differences between how such issues are perceived by “outsiders” compared to the way residents of disadvantaged and stigmatized communities view them. We hope that our findings will help develop culturally relevant health care practices and policies to address these wicked problems.

Literature review

Health disparities: Poverty and race

The World Health Organization (n.d.) defines social determinants of health as the “conditions in which people are born, grow, live, work and age,” and they consider these factors to be responsible for the health disparities evident within and between countries today. There is a growing public recognition that nonclinical factors, such as employment, education, race, ethnicity, and geography, influence health outcomes (Khullar & Chokshi, 2018). Poverty has long been recognized as a contributor to death and disease. There is an increased interest in the United States regarding the intersection between income and health as we have come to understand how economic inequity has broad health effects. For example, individuals residing in economically disadvantaged communities generally have higher rates of depression and obesity (Goodman et al., 2003; Grote et al., 2007). Poverty is not only viewed as impacting health outcomes; poor health is seen as impacting income too. Referred to as the health-poverty trap, this negative feedback loop creates barriers that make it increasingly difficult for an individual of low income to achieve positive health outcomes, and vice versa (Bor, Cohen, & Galea, 2017).

African Americans have worse health outcomes compared with Caucasians on both physical and mental health, and this disparity is across all age and income levels (CDC, 2017). The Centers for Disease Control and Prevention (CDC) reported that, in contrast to Caucasians, African Americans, ages 18-49, are twice as likely to die from heart disease, and are fifty percent more likely to have high blood pressure for the age group of 35-64 (CDC, 2017). A 2016 National Health Interview Survey revealed that 2.9% of African Americans reported poor health status in contrast with 1.8% among Caucasians (National Center for Health Statistics, 2017). Chronic health issues like diabetes, cardiovascular disease, hypertension, and obesity all tend to affect African Americans significantly more than other racial and ethnic groups. For example, cardiovascular disease mortality at the rate of per 100,000

persons for African Americans (321.3) is significantly higher than Asian/Pacific Islanders (137.4), Hispanics (188.4), and Caucasians (245.6) (Mayes et al., 2007). Furthermore, the Office of Minority Health (OMH) reported that compared to Caucasians, the death rate for African Americans was higher for heart disease, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide (OMH, 2018).

This study aimed to explore the intersection of poverty and race on health by discovering the effects of poverty stigma, community disorder, and feelings of unsafety for minority residents of a disadvantaged community in an urban area of central Florida. The study's findings inform a conceptual model explaining such effects for use by researchers, practitioners, and policymakers to understand better and thus create more effective healthcare responses. Social isolation theory (Wilson, 2012) and the theory of collective efficacy (Sampson, Raudenbush, & Earls, 1998) provide the theoretical underpinnings of the study.

Social isolation theory

Wilson's (1987) theory of social isolation refers to the separation of a group or individual from the larger society. It provides a conceptual backdrop for understanding how macro-level social and economic processes are connected to individual behavior (Fernandez & Harris, 1992). Wilson (1987) highlights how those residing in racial and economically disadvantaged communities become isolated because they have fewer social ties with individuals outside of their community. Squires and Kubrin (2014) also underscore how "racial segregation, in conjunction with the concentration of poverty and growing economic inequality, results in the growing isolation of poor minority households" (p. 348). Social isolation, thus, causes residents of economically disadvantaged communities to remain trapped as they are not only less likely to know individuals who can help them learn about job opportunities, but they are also less likely to have individuals modeling or adhering to larger societal norms (Tigges, Brown, & Green, 1998). This isolation reinforces economic inequality and leads to a lack of social power (Dreier, Mollenkopf, & Swanstrom, 2014).

Racially segregated communities in urban neighborhoods have historically been socially isolated from mainstream resources (Ousey, 2017). In turn, this isolation has been associated with sustained racial discrimination and segregation, socioeconomic inequality, and concentrated disadvantage.

Concentrated disadvantage is defined as a combination of factors such as unemployment, living below the poverty line, reliance on public assistance, restricted public services, racial stigma, an abundance of youth under 18, percentage of female-headed households, which intersect to produce major social stressors in communities (Becker, 2016). In turn, concentrated disadvantage is often associated with social isolation, which contributes to providing a suitable environment for crime to emerge (Anderson, 2012; Becker, 2018). As a result of these macro-level influences, there is an increased risk for residents

in such communities to be disengaged, have higher risk tolerance and lower self-control, and to be exposed to increased criminal behavior (Berezin et al., 2017; Ousey, 2017).

A major impact of social isolation is that socially isolated communities do not have the means or the resources to overcome their lack of power and to address the negative stigma associated with their community (Dreier, Mollenkopf, & Swanstrom, 2014). As a result of being cut off from the mainstream society, social isolation can cause stigma, and stigma can reinforce social isolation by making people avoid contacts with mainstream society or making people believe that the mainstream society does not want to be in contact with them (Biordi & Nicholson, 2013). Furthermore, communities that lack social power are not able to have their voices heard (Squires & Kubrin, 2014) and lack the resources to establish authority and status (Young, 2012).

Existing research studies on stigma primarily focus on its association with mental health issues (Sharac, Mccrone, Clement, & Thornicroft, 2010), HIV/AIDS (Cluver, Gardner, & Operario, 2008; Corrigan, 2004), non-traditional gender-identity (Hughto, Reisner, & Pachankis, 2015), and incarceration (Schnittker & John, 2007). Regarding poverty, a few studies have explored the reasons and nature of stigma (for example, Mickelson & Williams, 2008; Waxman, 1977); however, the effects of stigma on health status for communities experiencing concentrated disadvantage has not been fully explored (Reutter, Stewart, Veenstra, Love, Raphael, & Makwarimba, 2009).

Theory of collective efficacy

Collective efficacy is defined as a linkage of social control and cohesion combined with the desire to intervene for the common good (Morenoff, Sampson, & Raudenbush, 2001, Sampson, Raudenbush, & Earls, 1997). Social control is the capacity of a community to regulate its members according to commonly accepted principles (Janowitz, 1975). Social cohesion involves such components as trust, cooperation, solidarity, common values, and civic culture (Beauvais & Jenson, 2002; Chan, To, & Chan, 2006; Muntaner & Lynch, 1999). Sampson and colleagues (Sampson, Raudenbush, & Earls, 1997) found that higher levels of collective efficacy are generally associated with less violence. At the same time, higher rates of violence lead to lower levels of collective efficacy, forming a reciprocal self-reinforcing process (Sampson & Raudenbush, 1999).

Collective efficacy is greatly reduced by residential instability, lack of homeownership, family disruption, concentrated disadvantage, lack of trust, and lack of cooperation (Sampson & Wilson, 2013; Sampson, Raudenbush, & Earls, 1997). Gibson, Zhao, Lovrich, & Gaffney (2002) found that higher levels of collective efficacy were linked to lower levels of fear of crime in the community, which were associated with feelings of safety (Visser, Scholte, & Scheepers, 2013). Sampson & Wilson (2013) also indicate that low collective efficacy leads to an increased sense of disorder in the community, which has a self-reinforcing relationship with the fear of crime. Social disorganization theory suggests that

communities that have high rates of concentrated poverty, residential instability, and single-parent households lose the ability to impose social control over their surroundings (Bursik & Grasmick, 1993; Ousey, 2017; Triplett et al., 2005).

Instability in neighborhoods is characterized by resident turnover, which negatively affects social ties with others, especially in disadvantaged communities (Bursik & Grasmick, 1993). The lack of interpersonal relationships in the community also reduces the likelihood that neighbors will know the children in the area and will be less likely to intervene when they see children engaging in inappropriate behavior (like loitering or fighting) (Anderson, 1999). Furthermore, residential instability reduces the amount of informal surveillance, which can help mitigate crime. Drier and colleagues (2014) explain that violence can spontaneously erupt in impoverished neighborhoods, so people feel a propensity to defend themselves to survive. In general, a strong neighborhood network ultimately reduces crime, while those with weaker social ties in the neighborhood create an environment where crime can occur with little interference (Bursik & Grasmick, 1993; Sampson, 2012). Even the perception of disorder can dissuade efforts at empowering residents to develop a collective response to crime, which may also increase illegal activity (Anderson, 1999). Sampson (2012) suggests that disorder seen at the neighborhood level has a social meaning and has an inadvertent “feedback loop.” People tend to flee from high crime neighborhoods contributing to residential fluctuation. As a result, neighborhoods become stigmatized and can foster future and even generations of concentrated poverty.

Low collective efficacy leads to an increased sense of disorder in the community. A sense of disorder produces fear of crime, while fear of crime reproduces a sense of disorder (self-reinforcing relationship). Both sense of disorder and fear of crime lead to the perceptions of an unsafe environment (Visser et al., 2013). Community disorder also causes residents of the community to perceive the surrounding environment as unsafe (Visser et al., 2013). Fears of victimization and feelings of unsafety constitute a serious and pervasive public health problem (Mijanovich & Weitzman, 2003). Inner-city African American communities suffer from community disorder and violence more so than other communities (Bell & Jenkins, 1993). Furthermore, communities of concentrated disadvantage experience particularly devastating effects of violence on health compared to other communities (Leventhal & Brooks-Gunn, 2003).

Communities with high levels of instability drastically mitigate residents’ capacity to influence social control (Bursik & Grasmick, 1993; Triplett et al., 2005). Social disorganization is multi-leveled and is structured based on the interconnected relationships surrounding formal and informal tiers of association that influence social control in a neighborhood (Bursik & Grasmick, 1993). At the first level is the strength of the individual relationships that exist in the neighborhood. This first level forms the foundation of subsequent network levels. Strong relationships among neighbors then cultivate and

foster positive and reliable networks within the community. Theorists postulate that when neighbors know each other, they are more likely to notice situations and events that impact the collective good of the community. In turn, this thinking empowers citizens to use resources outside of the neighborhood from local government officials and the police to nonprofit organizations to help address serious issues like crime (Bursik & Grasmick, 1993). Consequently, collective efficacy provides a mechanism for community members to advocate and make changes to improve the general wellbeing of their community (Browning & Cagney, 2002).

Collective efficacy influences the health of community residents; it does so both directly, through the reduction of the level of stress residents have, and indirectly, through the reduction of community disorder (Ohmer, Teixeira, Booth, Zuberi, & Kolke, 2016). Browning and Cagney (2002) underscore how neighborhoods with higher levels of collective efficacy have a greater capacity to address health-compromising behavior, increase the quality and quantity of healthcare services provided to the community, and manage community health hazards. Irrespective of a community's socioeconomic status, scholars have argued that collective efficacy produces positive health outcomes because it underscores the mutual trust among community members and reflects the willingness for community members to intervene to address salient community issues (Browning & Cagney, 2002; Cohen et al., 2006).

Current study

This study used community-based participatory research methodology to explore residents' perceptions regarding the impact of stigma, community disorder, and feelings of unsafety on their health. Community-based participatory research (CBPR) is an overarching term that refers to a research design that promotes the active and equal participation of community members in the research process (O'Fallon & Dearth, 2002). Ahmed and Palermo (2010) argue that community-based participatory research represents a type of community engagement that can improve the community's ability to address its own health needs. Similarly, Wallerstein and Duran (2010) note that community-based participatory research is "a transformative research paradigm that bridges the gap between science and practice through community engagement and social action to increase health equity" (p. 540).

Methods

Twenty-three residents participated in the study. The median age of participants was 40 and ranged in age from 27 to 81 years old. Most participants were African American (87%), female (87%), had children living at home (78%), and received Medicaid/Medicare (70%). More than half of the participants were single (57%), unemployed (61%), had a high school education or less (57%), or had an income of \$10,000 or less (52%). The average number of years participants had resided in The Vicinity community was 18

years (minimum was 1 year, and the maximum was 61 years). The demographic characteristics of the sample were consistent with the demographic characteristics of the population (n=4,500) except for employment status and gender. Table 1 summarizes the descriptive statistics of the sample in comparison to the population of The Vicinity.

Table 1. Demographic characteristics of the population and sample

		Population	Sample
Race/Ethnicity	Black	71%	87%
	White	13%	4.3%
	Hispanic/Latino	12%	4.3%
Sex/gender*	Female	46%	87%
	Male	54%	13%
Age	Median	28	40
Children in household	Yes	25%	78%
	No	75%	22%

* The U.S. Census provides data on sex, while the questionnaire administered to the participants of this study asked the respondents to identify their gender. Population data are from the U.S. Census (2010). See Limitations section for more information on this.

This study used purposive homogeneous sampling where participants have a shared set of characteristics (Strauss & Corbin, 1994). In this study, participants were similar in terms of race, culture, lived experience, and geographical location. Additionally, purposive sampling “involves identifying and selecting individuals ... that are especially knowledgeable about or experienced with a phenomenon of interest” (Palinkas et al., 2015, p. 2). By using this sampling technique, the researchers intentionally invited participants residing in The Vicinity as they were deemed to have the most culturally relevant insights regarding the health status of their community.

Upon obtaining approval from the university internal review board, the research team recruited study participants through advertisements in the local community, social networks, and online event board posts. Recruitment flyers were also handed out to people on the street in addition to posting

hardcopies on advertisement boards in neighborhood establishments. Additionally, a series of local organizations reached out to community members through certain social groups that residents trusted (for example, churches, schools, and family restaurants). Lastly, an online posting with information about the study was posted on a community social media site. To be included in the study, participants had to be 18 years or older, and a current resident of one of the three neighborhoods comprising The Vicinity.

Participants were invited to participate in evening focus groups at a local community center. Study participants were divided into six focus groups, each consisting of three or more people based on their residence census tract blocks to encourage a collective voice specific to their geographical location. Focus groups were audio-recorded and approximately 60 minutes in duration. Participants were compensated for their time, and each received a \$20 gift card. Additionally, dinner was catered by a local eatery, and childcare supervision was provided. Participants were asked to sign an informed consent form advising them of their rights, confidentiality protective measures, voluntary status, as well as the purpose of the study. Pseudonyms were selected by participants and used for all study procedures and documentation. Focus groups have emerged as a common qualitative methodological approach in health research, as they bring together a group of individuals that have experienced or are currently experiencing similar health-related issues (Wilkinson, 1998). The interview guide and survey instruments were reviewed by community members for their input before conducting the study. The final interview guide consisted of six open-ended questions: 1) Think about the last time you were sick or had a health-related need, where did you turn for information and services? Please explain if you did not seek information or services, and please explain your experiences regarding your patient-provider relationship. 2) What are the barriers to a healthy lifestyle in relation to your physical environment? 3) In what ways does income impact your health? 4) How would you describe the impact of crime (drug crime and violent crime) on your community's health? 5) How are you involved in the decisions to improve the health of your community? And, 6) Is there anything else you'd like us to know about the health needs in your community?

After each focus group, participants completed survey items regarding demographic characteristics (e.g., age, gender, and race/ethnicity), socioeconomic characteristics (such as children living in the home, employment, and income), and other community-based questions (e.g., whether the participants utilized community resources and whether they had witnessed acts of violence in their community).

Data analysis

Quantitative and qualitative data were analyzed separately. SPSS version 25 was used to run descriptive statistics on survey items. Thematic analysis for qualitative inquiry involved “identifying, analyzing, organizing, describing, and reporting themes found within a data set” (Nowell, Norris,

White, & Moules, 2017, p. 2). This methodology allows researchers to assess qualitative data for common themes in order to understand participants' perceptions and experiences regarding social issues so that appropriate solutions can be developed and implemented. Focus groups were transcribed verbatim and uploaded to the online qualitative analysis software Dedoose (www.dedoose.com). A codebook was developed, and all transcripts were coded by two researchers to increase reliability (Sapat, Schwartz, Esnard, & Sewordor, 2017). The codebook established a set of codes, such as where respondents turn to for health services and information, the barriers to maintaining a healthy lifestyle, and what participants believe needs to be done to improve the health of their community. Excerpts with conflicting coding were discussed and a decision was made among the research team regarding the most appropriate coding to be applied.

Data were analyzed using a constant comparison method, which refers to “a method of coding and analyzing data through three stages: open coding (examining, comparing, conceptualizing, and categorizing data); axial coding (reassembling data into groupings based on relationships and patterns within and among the categories identified in the data); and selective coding (identifying and describing the central phenomenon or core category in the data)” (Starks & Brown Trinidad, 2007, p. 1376). To start with, the researchers identified the following open codes (categories): isolation, collective efficacy, stigma, safety, policing, and health. As a result of axial coding, authors identified properties and dimensions within each open code category and reassembled qualitative data into the following groupings: poverty, lack of resources, and lack of conventional role models for the isolation category; social capital, social cohesion, and systemic barriers for the collective efficacy category; internal and external stigma for the stigma category; drugs, community violence, sense of disorder, and fear of crime for the safety category; police brutality and police disrespect for the policing category; and direct harm, stress, and unhealthy lifestyle for the health category. Then selective coding was performed whereby the author looked between code categories to determine how they relate to one another. For example, the author examined how poverty leads to stigma, social isolation and collective efficacy; how stigma influenced the level of stress and feelings of unsafety experienced by the community members; the self-reinforcing cycle of low collective efficacy, sense of disorder, and fear of crime; as well as many other relationships. This will be discussed in more detail in the next section. To ensure inter-coder reliability, at least two members of the research team individually coded all focus group interview transcripts (Cho, 2017). Differences in coding were resolved by consensus.

Results

Participants described their community as being isolated from other, primarily wealthier communities. Isolation involved a lack of access to transportation, grocery stores, healthcare facilities, as well as safe and adequately equipped community parks. It was noted that even restaurants in neighboring areas refused to deliver food to The Vicinity. Additionally, participants frequently

underscored how they believed that “outsiders” often perceived The Vicinity as a place where all residents were viewed as drug addicts and criminals. Such external stigmatization was often internalized by residents preventing them from collectively addressing social issues in their community. Participants reported a lack of trust and cooperation among residents. Comparing their neighborhood experiences in the past to the present, many agreed that people do not have the same sense of community they used to have before.

Participants noted safety as the central concern for their community. Not a single person stated they felt safe where they lived. Participants were united in their perception of their neighborhood as an unsafe place where crime prevailed day and night. In terms of safety risks, three primary conditions were identified: street violence (gun shootings, fighting, and other types of disorder), drugs (sales and use), and police misconduct (brutality toward offenders at the time of arrest and disrespect toward ordinary citizens and their rights).

Social isolation and stigma

Study participants mentioned numerous times that people from outside of The Vicinity see them as uneducated drug addicts and criminals. Ms. Gee, age 79, stated, “We just have seen so much through the years. People come along to The Vicinity and say, ‘They’re not educated.’” Little Bit, age 61, echoed such sentiment, “They already think that The Vicinity area is the worst area [in the city].” Pear Shady, age 44, also noted, “I believe the reason why they [businesses] don’t deliver over here is because they think they’re going to get robbed or shot or something bad might happen to them.”

Participants also noted that they were tired and frustrated with not being listened to by politicians. Even when politicians made it look like they listened (usually, before an election), residents did not feel their voices were heard.

It’s an observation—[about not being listened to] as if the community doesn’t know what’s best for themselves and others have to share and come in and tell them. ... the people in the community ... have been prejudged too much. It hurts a lot to be in meetings or hear people saying they mean well, but you don’t even ask me how I feel or what has gone on. So, the barrier is to be prejudged. That is a really hurtful thing in this community. ... What we’ve been saying a lot in our community lately is if you’re not at the table, you’re part of the menu, and we’re tired of being a part of the menu. (Buddy Doom, age 56)

External stigmatization has spread within the community, and even people living in The Vicinity often believe that there is something wrong with them and that they do not deserve a better life. This, in turn, affects social cohesion among the residents. Little Bit, age 61, stated, “I know back in the days we all looked out for one another and now it’s like everybody is against each other instead of trying to come together as one.”

Safety: Street violence

Gun shootings

Over 60% of study participants agreed that street violence is a problem in The Vicinity. Participants reported that gun shootings happen daily and that people get hurt regularly. Most participants reported losing a family member due to gun violence. Parents, therefore, do not let their children go outside even during the day. Pear Shady, age 44, stated, “Me and my kids, we used to go to the park all the time, but now it’s like too scared to even walk out of the house because of the way people coming around shooting up people.” And Florida, age 42, agreed, “They shoot every night. You don’t hear nothin’ but gun, gun, gun ... All day. All night.” Exposure to gunshots every day creates constant stress for residents of The Vicinity.

My kid don't go outside. I won't let him go to the store. He's [her son] wondering why he can't go outside with his bicycle. I mean from the time you wake up until you go to sleep, you hear gun shootings, but if you don't hear that, then on the corner, there's someone dead. We've been having like so many people dead at least once a week, someone is on the corner dead or in the yard dead. ... You'll be scared to see your own kids out there. You see these shootings, up at the park getting shot at, and you see innocent kids getting shot up. ... You'll hear gunshots every single night before you go to sleep, and after a while you sleep, you [wake up] to hear gunshots. That's what you hear where I live at. (Ontario, age 35)

Just lost my god brother a couple of years ago due to them just shooting like crazy at the park right here at the community center basketball court ... I don't even like my little brother going nowhere especially like that because you know, no telling when the last time you're going to see him or whatever. (Shady Lake, age 19)

Fighting and other types of disorder

Besides regular exposure to gunshots, participants identified several other types of public disorder (e.g., different types of crime) that create a constant sense of fear among the residents and prevent them from leaving their homes. Mothers reported not allowing their kids to play outside, and elders expressed fear at coming outside even to check their mail. No participant indicated that community parks for residents were safe. All complained about drug dealers and drug users, as well as those using alcohol and homeless individuals, occupying parks during the hours they are open. Ontario, age 35, noted, “Up in the hood, you don't have nothing for kids to play on. So, the kids do what they do. There's fighting and stuff like that because they don't have anything to play on.” Florida, age 42, stated, “All it is around here is straight crime, crime, crime everywhere. When you're walking down the street or whatever, you'll probably run into some violence.”

Especially, [the community center park] have all alcoholics out there laying down on the ground pissin' all over, wake up, smoking, and everything. So, if the kids do decide to come out and they'll see them. You don't know if they're a rapist, kidnappers, you don't know what they is. (Bentley, age 38)

Safety: Drugs

Drug sales

Over 65 percent of study participants said that drugs are a community problem in The Vicinity. They highlighted how drug dealers did not try to hide from anybody and did not stop their “work” even when kids are going to and from school. Little Bit, age 61, stated how “the drug crime in the area is very bad because you have guys out in front of the little bitty kids selling drugs.” Participants’ comments underscore the frustration and helplessness regarding the extent of the drug problem in the community.

I would be afraid to let my child go out the door. He always used to want to go play with other kids and I told him no because too much drugs deals and if they aren't doing that, they are fighting going over there. So, I tell my son, ‘No, stay in the house with me. Cause mama ain't got no money to bury you.’ (Bentley, age 38)

Drug use

Participants reported how drug users had occupied all the community parks in The Vicinity. People can no longer bring their children to the parks because during the day, there are groups of drug users who are not hesitant to use drugs openly in the park.

A lot of stuff goes on at a park, like they smoke their weed and their Marley's, and all this and all that around the kids or whatever. So how can the kids be enjoying themselves at the park when it's a lot of drug activity going on around the kids, you know what I'm saying? That's crazy. (Florida, age 42)

Like I said, a park is supposed to be a park for the kids, not for the drugs and all that. There ain't no park for the kids like Bentley said, they sleep out there and drink and everything. All types of stuff be going on at the park. (Ontario, age 35)

Safety: Police misconduct

Brutality

Participants reported that police officers do not hesitate to enforce the law very harshly and do not think twice before deciding to apply force toward people.

When you are arrested, the way people are treated ... if you commit a crime, you're supposed to go to jail, but you don't have to be beaten in front of young people and children. So, we have a problem with law enforcement ... in our community. ... when kids constantly see police beatings and doing people wrong, it's traumatizing. Even me when the cops come, I start shaking. I don't know how they're gonna treat me. Am I going to survive this? Am I going to get a good officer? Am I going to get a bad officer to talk to me like I'm a dog? It's happening in this community. So, people are traumatized mostly. And you know what trauma does, it affects your health. (Buddy Doom, age 56)

Disrespect

Participants noted that police officers treat everybody who lives in The Vicinity with a degree of disrespect, considering them all to be criminals.

The police, they harass everybody. The police come in this area and everybody's a drug user to them. It doesn't matter how old you are, doesn't matter. And that's not fair that everybody should be targeted. They harass people and that's not fair. It's not fair. Like just because you live over here, or from over here, doesn't mean you should get targeted because it's not where you live, it's how you live. (Mookie, age 32)

In discussing police officers' disrespect to the community and its residents, some mentioned that such disrespect often results in negligence and sometimes in harm to people living in the neighborhood. Florida, age 42, stated, "They'll be coming down the residential areas [where] 20 and 25 miles is the speed limit and, you know, they're doing like 45-50."

A lady was just killed. I remember that lady. The lady was on the side of the road and the police was chasing a car down. Killed the lady on the sidewalk for no reason 'cause he tried to chase the car ... The police killed her trying to chase a car. (Ontario, age 35)

Health: Stress

Stress was the most widely cited health problem in the community. Participants discussed two types of stress: stress caused by stigma and stress caused by feelings of unsafety.

Stress caused by stigma

Disrespectful attitudes by police officers, racism toward neighborhood residents, and constant high crime rates expose residents to both internal and external stigma.

My son is a young black man ... even though he's not participating in crime, there is crime all around us and you don't have to be doing something wrong in order for something bad to happen to you. So that's how it impacts me. It's one of the reasons I guess I have high blood pressure; I

worry a lot and that's one of my biggest worry. He's my only child, so knowing that he's in this world out in this world and there's so much crime, it worries me a lot. (Country Girl, age 40)

Stress caused by feelings of unsafety

Daily stress experienced by community residents is also caused by the feeling of living in an unsafe neighborhood. Nay, age 64, stated, "You can't go to the mailbox, you know, you scared to go out. I'll put it out there I am scared to go out. And it causes stress. It's just a stressful." Shady Lady, age 19, also noted, "You never know when gunshots or any of that's gonna take part because bullets have no one's name on it and therefore with things like that we get paranoid because we don't know what's going to happen next."

I have to be to work at 6:00 in the morning and I take the bus so it's like dark when I'm walking to the bus stop. So, I'm always, you know, looking back and I'm hearing noises and it's like scary. (Country Girl, age 40)

Health: Direct harm

Harm produced by violence

Several study participants acknowledged how gun shootings and fights often harm innocent people. For example, Shady Lake, age 19, said, "I don't feel comfortable going to the local parks nowadays because they got too many knuckleheads out there with guns and acting stupid."

Harm caused by unhealthy lifestyle

Due to being under constant fear of crime, participants simply cannot maintain a healthy lifestyle. As such, they cannot walk outside, organize and attend community events, or feel safe in going to the park.

I would say the impact of crime as far as how it affects the community health would be where everybody's too like worried or afraid of even going to parks. (Brooklyn, age 33)

If I come out and I hear somebody like from outside my house arguing, saying, 'I'll kill you bitch', I close my door 'cause it ain't safe. And I say, 'A gun ain't got no eyes.' So, I just stay in the house. (Bentley, age 38)

Discussion

Social isolation theory (Wilson, 2012) and the theory of collective efficacy (Sampson, Raudenbush, & Earls, 1998) were used as theoretical frameworks for this research. This study's findings align with the main propositions of these theories. The Vicinity has similar characteristics of a socially isolated

community regarding concentrated poverty, racial segregation, lack of employment opportunities, stigma, and deprivation of resources that mainstream society has access to. Predominantly black neighborhoods that are perceived as being poor are disproportionately stigmatized by “outsiders” (Loury, 2003; Phelan, Link, Moore, & Stueve, 1997). In other words, external stigmatization can precede social isolation. At the same time, as a result of living in a socially isolated community, one can experience internal stigmatization (or self-stigmatization), which develops through the process of cultural adaptation (Wilson, 2012). Cultural adaptation occurs when generations of people live in the same conditions (such as when people live in social isolation). Constantly living in a community with insufficient resources and where very few people have stable employment or violate the laws (conventional role models to which the mainstream society normally has access) results in cultural adaptation (Wilson, 2012). One of the consequences of this cultural adaptation caused by social isolation is that it often results in internal stigmatization, an emotional state in which an individual continually feels shame and expects some form of discrimination (Saridi, Kordosi, & Souliotis, 2015). While external stigma is generally a cause of social isolation, internal stigma is usually a consequence of the community isolation from mainstream society.

Due to the absence of reliable public transportation in the city, The Vicinity is cut off from the healthcare system, job market, grocery stores, restaurants, and recreational spaces. As a result of this social isolation, residents feel separated from mainstream society and forgotten by others, mainly city administrators, policymakers, and other city institutions. This perception of being forgotten, combined with constantly living in a community with insufficient resources and lack of conventional role models, results in an internal stigma and is reflected in the lack of trust in state authorities and organizations. Multiple participants mentioned that they felt like it was only immediately before the elections that they received a certain degree of attention from politicians and that once the elections are over, politicians would disappear, leaving residents with their community problems. Participants recognized how external and internal stigmatization caused a great deal of stress for them.

In addition to social isolation, participants reported that the neighborhood is characterized by substantial systemic barriers (e.g., concentrated disadvantage). Furthermore, they noted an evident lack of communication of shared expectations among the residents, as well as low interpersonal trust and low level of cooperation. This leads to decreased collective efficacy and an increased sense of community disorder among residents of The Vicinity. Participants reported that they felt like drugs were being sold everywhere in the community and that all recreational areas were unavailable for children due to being occupied by drug users and the homeless. The sense of disorder produces the fear of crime, which then reinforces the sense of disorder, lack of communication, trust, and cooperation. In accordance with social disorganization theory (Bursik & Grasmick, 1993; Ousey, 2017; Triplett et al., 2005), residents reported not only having a sense of disorder but also being fearful of violence on the street which prevented them from leaving their homes. Many respondents mentioned

that they would not allow their children to play outside because they did not think it was safe. Additionally, participants indicated that they were not going to parks or gyms, and therefore, could not maintain a healthy lifestyle, due to feelings of unsafety.

Participants indicated that there were almost no community-level events in the area. They noted that it prevents residents from effectively communicating with one another and sharing expectations among the people living in the area. Due to a lack of communication among residents, there is also a lack of trust. Thus, people cannot rely on one another and intervene if a deviant act is observed because they do not know what to expect from other community residents. While in the past, people would intervene if they observed disorderly conduct outside of their home; these days, nobody comes out of home, especially in the evenings.

Both social isolation and collective efficacy theories posit that if the subject condition is present (social isolation or low collective efficacy respectively), the community will have high rates of crime and public disorder (Sampson, Raudenbush, & Earls, 1998; Wilson, 2012). This is precisely what The Vicinity residents reported during the focus group interviews. Several study participants said that they hear gunshots every night and that people die every week. Multiple residents expressed concerns with drug dealers selling drugs without even attempting to hide it and drug users using drugs in public spaces, including parks and sidewalks by public schools where their children attend. Several study participants noted that the police are not respectful toward community residents, which adds to their internal stigmatization. Additionally, police frequently use excessive force, which leaves many people unjustly injured.

This study's findings highlight how stigma, community disorder, and feelings of unsafety have both direct and indirect effects on the health of the community residents. As such, aside from the substantiated bilateral relationship between poverty and social isolation (Wilson, 2012), we found that external community stigma resulting from the community being viewed as disadvantaged (mainly, as traditionally African American and poor) causes social isolation. Social isolation, in turn, results in an internal stigma experienced by the community residents due to prolonged living in a disadvantaged neighborhood in isolation from the mainstream society and understanding that from the outside, people view their neighborhood as disadvantaged. What is particularly interesting is that this study shows that self-stigmatization has a reciprocal relationship with social isolation the same way as social isolation interacts with poverty, thereby creating a complex self-reinforcing circle.

Besides the relationship social isolation has with external and internal stigma, it also erodes community cohesion and social control in the neighborhood, thereby reducing the level of collective efficacy in the community. This study results further confirm reduced levels of collective efficacy result in an increased sense of disorder and fear of crime, which in turn affects collective efficacy

creating another self-reinforcing circle of disadvantage. Further, the sense of disorder and fear of crime results in residents feeling unsafe in the community.

This study's findings indicate how increased social isolation and decreased collective efficacy both contribute to community disorder. Intertwined with internal stigma and residents' feelings of unsafety, community disorder directly harms residents' health through the normalization and prevalence of drug use, community violence, and police misconduct. In addition to being directly harmed by community disorder, community residents' health is also directly affected by the stress and depression caused by stigma and unhealthy lifestyle resulting from the inability of the people living in the community to maintain a healthy lifestyle due to feelings of unsafety.

Our findings suggest a conceptual model that illustrates how stigmatization, community disorder, and feelings of unsafety manifest in the community, and how, in turn, they affect residents' health in communities with social isolation and low collective efficacy (see Figure 1). Based on participants' perspectives, it appears that the most severe harm to residents' health is caused by community disorder (people regularly die due to drug overdose and violence). At the same time, while stress and living an unhealthy lifestyle, do impact people's lives instantly, it does affect the entire community as opposed to criminal behavior that may impact only certain individuals. This study did not differentiate various factors affecting residents' health in terms of the strength of such impact or to compare the effects of these factors with the direct effects of poverty on health. This would be an important topic for future research.

Figure 1. Conceptual model of how stigma and perceptions of unsafe environment are shaped in the community, and how they, in turn, shape health in communities with low collective efficacy and high level of social isolation

Limitations

One of the limitations of the findings is generalizability. Although conventionally deemed sufficient (Guest, Bunce, & Johnson, 2006), the sample size of 23 interviewees might not reflect the real perceptions of residents from The Vicinity (n=approximately 4,500). A comparative analysis of the demographic characteristics of the sample with the demographic characteristics of the population revealed some differences. As such, the proportion of unemployed people is higher in the sample than in the population. This is understandable and expected for any qualitative study of this kind as it is reasonable to assume that unemployed people have more time and desire to participate in research studies than those who work full-time. In any way, this unlikely constitutes a problem since the subject study is primarily interested in the low-income population. Those who are unemployed are

more likely to be poor. Another demographic difference between the sample used in this project and the population characteristics is the male to female ratio. While comprising only 46% of the population, females represented 87% of the study participants. A similar difference exists between the sample and the population with respect to the race/ethnicity: blacks comprised 87% of the study sample while their proportion in the population is 16% less. The latter two limitations may potentially bias the study findings as men and women may have different perceptions of safety and stigma. Existing research suggests that ethnic minorities and women tend to experience stigma more than whites and males (Roeloffs et al., 2003). This would be an interesting research topic for future studies, both quantitative and qualitative, with a larger sample.

Policy implications

This study's results indicated that both social isolation and low collective efficacy play a role in the negative health outcomes of residents of The Vicinity. The city's Comprehensive Neighborhood Plan (2015) provides guidelines on transforming the Vicinity into a healthy and sustainable community. The plan suggests a variety of activities intended to improve living conditions in the community. These activities include (1) provision of residents with accessible transportation options, (2) affordable housing, (3) creation of a unique Vicinity identity which aims to push economic development, (4) provision of access to labor market and job opportunities, (5) promotion of social justice, and (6) promotion of access to healthy food and lifestyle. Although The Vicinity Comprehensive Neighborhood Plan (2015) partly addresses the causes of social isolation and takes the direct relationship between poverty and health outcomes into account, along with steps to remediate these problems, nothing in the plan suggests any steps to improve collective efficacy of residents.

Steps should be taken to encourage communication among the residents and improve their level of trust to one another, thereby creating a sense of community and boosting the level of collective efficacy. To increase communication, periodic social events in the community are necessary (Ohmer, 2007). Increased communication provides an avenue for residents to share their expectations, which can improve the level of trust and collaborative capacity in the community.

It is important to understand that only systematic solutions that will address all main social problems existing in The Vicinity at once have a chance to be effective. If the causes of low collective efficacy are not addressed while the causes of social isolation are eliminated, it is unlikely that such an intervention will produce any noticeable effect. Strengthening collective efficacy in conjunction with addressing the causes and reinforcers of social isolation might help to eliminate negative consequences of stigma and perceptions of an unsafe environment, as well as reduce the crime rates; all of which may reflect positively on the health of residents in The Vicinity.

Conclusion

This study's findings highlight how a sense of stigma and feelings of unsafety, as well as community disorder, influence health outcomes for The Vicinity residents. Based on the results of the study, a conceptual model is presented that illustrates how stigma, violence, and perceptions of unsafe environment affect health outcomes in communities with social isolation and low collective efficacy is presented. This study contributes to a body of research on the effects of social isolation and low collective efficacy on health outcomes by demonstrating how stigmatization, violence, and residents' perceptions of safety can shape health outcomes in low-income communities. Policymakers and researchers can use the results of this study to develop more effective strategies to improve health outcomes in communities of concentrated disadvantage.

References

- Ahmad, F., Medder, J., Geske, J., Taylor, J., & Margalit, R. (2017). Mental health problems due to community violence exposure in a small urban setting. *Family Medicine and Community Health*, 5(3), 170-178.
- Ahmed, S. M., & Palermo, A. G. S. (2010). Community engagement in research: frameworks for education and peer review. *American Journal of Public Health*, 100(8), 1380-1387.
- Aisenberg, E. & Ell, K. (2005). Contextualizing community violence and its effects: An ecological model of parent-child interdependent coping. *Journal of Interpersonal Violence*, 20(7), 855-871.
- Anderson, E. (2000). *Code of the Street: Decency, Violence, and the Moral Life of the Inner City*. New York, NY: Norton & Company.
- Beauvais, C., & Jenson, J. (2002). *Social cohesion: Updating the state of the research* (Vol. 62). Ottawa: CPRN.
- Becker, J. H. (2016). The dynamics of neighborhood structural conditions: The effects of concentrated disadvantage on homicide over time and space. *City & Community*, 15(1), 64-82.
- Bell, C. C. & Jenkins, E. J. (1993). Community violence and children on Chicago's southside. *Psychiatry*, 56(1), 46-54.
- Biordi, D. L., & Nicholson, N. R. (2013). Social isolation. In I. M. Lubkin (Ed.), *Chronic illness: Impact and intervention*, (pp. 85-115). Burlington, MA: Jones & Bartlett Learning.
- Bjartveit, K., & Tverdal, A. (2005). Health consequences of smoking 1-4 cigarettes per day. *Tobacco Control*, 14(5), 315-320.

- Braveman, P. & Gottlieb, L. (2014). The social determinants of health: It's time to consider the causes of the causes. *Public Health Reports*, 129(1), 19-31.
- Browning, C. R., & Cagney, K. A. (2002). Neighborhood structural disadvantage, collective efficacy, and self-rated physical health in an urban setting. *Journal of Health and Social Behavior*, 43(4), 383-399.
- Bursik, R. J., & Grasmick, H. G. (1993). Economic deprivation and neighborhood crime rates, 1960-1980. *Law & Society Review*, 27(2), 263-285.
- Caetano, R., Field, C. A., & Nelson, S. (2003). Association between childhood physical abuse, exposure to parental violence, and alcohol problems in adulthood. *Journal of Interpersonal Violence*, 18(3), 240-257.
- Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, 359(9314), 1331-1336.
- Centers for Disease Control and Prevention (CDC). (2017). *African American health*. Retrieved from <https://www.cdc.gov/vitalsigns/aahealth/index.html>
- Chan, J., To, H. P., & Chan, E. (2006). Reconsidering social cohesion: Developing a definition and analytical framework for empirical research. *Social Indicators Research*, 75(2), 273-302.
- Chen, C. Y., & Lin, K. M. (2009). Health consequences of illegal drug use. *Current opinion in psychiatry*, 22(3), 287-292.
- Chiolero, A., Faeh, D., Paccaud, F., & Cornuz, J. (2008). Consequences of smoking for body weight, body fat distribution, and insulin resistance. *The American Journal of Clinical Nutrition*, 87(4), 801-809.
- Cho, J. (2017). *Evaluating qualitative research*. London: Oxford University Press.
- Cluver, L. D., Gardner, F., & Operario, D. (2008). Effects of stigma on the mental health of adolescents orphaned by AIDS. *Journal of Adolescent Health*, 42(4), 410-417.
- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, 59(7), 614.
- De Donder, L., Buffel, T., Dury, S., De Witte, N., & Verte, D. (2013). Perceptual quality of neighbourhood design and feelings of unsafety. *Ageing & Society*, 33(6), 917-937.
- Dutton, M. A., Green, B. L., Kaltman, S. I., Roesch, D. M., Zeffiro, T. A., & Krause, E. D. (2006). Intimate partner violence, PTSD, and adverse health outcomes. *Journal of interpersonal violence*, 21(7), 955-968.
- Farrall, S., Bannister, J., Ditton, J., & Gilchrist, E. (2000). Social psychology and the fear of crime. *British Journal of Criminology*, 40(3), 399-413.

- Fernandez, R., & Harris, D. (1992). Social isolation and the underclass. In A. Harrell & G. Peterson (Eds.), *Drugs, crime, and social isolation: Barriers to urban opportunity* (pp. 257-293). Washington, DC: The Urban Institute Press.
- Fowler, P. J., Tompsett, C. J., Braciszewski, J. M., Jacques-Tiura, A. J., & Baltes, B. B. (2009). Community violence: A meta-analysis on the effect of exposure and mental health outcomes of children and adolescents. *Development and Psychopathology*, 21(1), 227-259.
- Gardner, L., & Shoemaker, D. J. (1989). Social bonding and delinquency: A comparative analysis. *The Sociological Quarterly*, 30(3), 481-499.
- Gibson, C. L., Zhao, J., Lovrich, N. P., & Gaffney, M. J. (2002). Social integration, individual perceptions of collective efficacy, and fear of crime in three cities. *Justice Quarterly*, 19(3), 537-564.
- Goodman, R. A., Bunnell, R., & Posner, S. F. (2014). What is “community health”? Examining the meaning of an evolving field in public health. *Preventive Medicine*, 67(1), 58–61.
- Gottfredson, M. R., & Hirschi, T. (1990). *A general theory of crime*. Stanford University Press.
- Green, L. W. & Anderson, K. L. (1986). *Community health*. Los Angeles, CA: Times Mirror Magazine.
- Green, L.W. & Ottoson, J.M., (1999). *Community and population health, Eighth edition*. Boston, MA: WCB/McGraw-Hill.
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field methods*, 18(1), 59-82.
- Horgan, C., Skwara, K. C., Strickler, G., & Andersen, L. (2004). *Substance abuse: The nation's number one health problem*. Diane Publishing Company.
- Hughto, J. M. W., Reisner, S. L., & Pachankis, J. E. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Social Science & Medicine*, 147, 222-231.
- Hussey, J. M., Chang, J. J., & Kotch, J. B. (2006). Child maltreatment in the United States: prevalence, risk factors, and adolescent health consequences. *Pediatrics*, 118(3), 933-942.
- Irish, L., Kobayashi, I., & Delahanty, D. L. (2009). Long-term physical health consequences of childhood sexual abuse: A meta-analytic review. *Journal of Pediatric Psychology*, 35(5), 450-461.
- Janowitz, M. (1975). Sociological theory and social control. *American Journal of Sociology*, 81(1), 82-108.
- Kilpatrick, D. G., Ruggiero, K. J., Acierno, R., Saunders, B. E., Resnick, H. S., & Best, C. L. (2003). Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: results

from the National Survey of Adolescents. *Journal of Consulting and Clinical Psychology*, 71(4), 692.

Kilpatrick, D. G., Saunders, B. E., Resnick, H. S., & Smith, D. W. (1995). *The national survey of adolescents: Preliminary findings on lifetime prevalence of traumatic events and mental health correlates*. Charleston: Medical University of South Carolina, National Crime Victims Research and Treatment Center.

Kindig, D., & Stoddart, G. (2003). What is population health? *American Journal of Public Health*, 93(3), 380-383.

Kliewer, W., Lepore, S. J., Oskin, D., & Johnson, P. D. (1998). The role of social and cognitive processes in children's adjustment to community violence. *Journal of Consulting and Clinical Psychology*, 66(1), 199-209.

Krug, E. G. (2002). *World report on violence and health*. Geneva: World Health Organization.

Lang, A. J., Kennedy, C. M., & Stein, M. B. (2002). Anxiety sensitivity and PTSD among female victims of intimate partner violence. *Depression and Anxiety*, 16(2), 77-83.

Lavizzo-Mourey, R. (2014). *Building a culture of health: 2014 president's message*. Retrieved from http://www.rwjf.org/content/dam/files/rwjf-web-files/Annual_Message/2014_RWJF_AnnualMessage_final.pdf

Leventhal, T., & Brooks-Gunn, J. (2003). Moving to opportunity: An experimental study of neighborhood effects of mental health. *American Journal of Public Health*, 93(3), 1576-1582.

Lindert, J., & Levav, I. (2015). *Violence and mental health: Its manifold faces*. Dordrecht, Netherlands: Springer.

Lindert, J., Bilsen, J., & Jakubauskiene, M. (2017). Public mental health. *European Journal of Public Health*, 27(4), 32-35.

Lindert, J., von Ehrenstein, O. S., Grashow, R., Gal, G., Braehler, E., & Weisskopf, M. G. (2014). Sexual and physical abuse in childhood is associated with depression and anxiety over the life course: systematic review and meta-analysis. *International Journal of Public Health*, 59(2), 359-372.

Loury, G. C. (2003). Racial stigma: Toward a new paradigm for discrimination theory. *American Economic Review*, 93(2), 334-337.

Maker, A. H., Kemmelmeier, M., & Peterson, C. (1998). Long-term psychological consequences in women of witnessing parental physical conflict and experiencing abuse in childhood. *Journal of Interpersonal Violence*, 13(5), 574-589.

- Malinosky-Rummell, R., & Hansen, D. J. (1993). Long-term consequences of childhood physical abuse. *Psychological Bulletin*, 114(1), 68.
- Margolin, G., & Gordis, E. B. (2000). The effects of family and community violence on children. *Annual Review of Psychology*, 51(1), 445-479.
- Margolin, G., & Gordis, E. B. (2004). Children's exposure to violence in the family and community. *Current Directions in Psychological Science*, 13(4), 152-155.
- Marmot, M., Friel, S., Bell, R., Houweling, T. A., & Taylor, S. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. *The Lancet*, 372(9650), 1661-1669.
- McBride, P. E. (1992). The health consequences of smoking: Cardiovascular diseases. *Medical Clinics of North America*, 76(2), 333-353.
- McKenzie, J.F., Pinger, R.R., & Kotecki, J.E. (2005). *An introduction to community health*. Boston, MA: Jones and Bartlett Publishers.
- Mechanic, M. B., Weaver, T. L., & Resick, P. A. (2008). Mental health consequences of intimate partner abuse: A multidimensional assessment of four different forms of abuse. *Violence Against Women*, 14(6), 634-654.
- Mickelson, K. D., & Williams, S. L. (2008). Perceived stigma of poverty and depression: Examination of interpersonal and intrapersonal mediators. *Journal of Social and Clinical Psychology*, 27(9), 903-930.
- Mijanovich, T., & Weitzman, B. C. (2003). Which "broken windows" matter? School, neighborhood, and family characteristics associated with youths' feelings of unsafety. *Journal of Urban Health*, 80(3), 400-415.
- Morenoff, J. D., Sampson, R. J., & Raudenbush, S. W. (2001). Neighborhood inequality, collective efficacy, and the spatial dynamics of urban violence. *Criminology*, 39(3), 517-558.
- Muntaner, C., & Lynch, J. (1999). Income inequality, social cohesion, and class relations: a critique of Wilkinson's neo-Durkheimian research program. *International Journal of Health Services*, 29(1), 59-81.
- Newcomb, M. D., & Bentler, P. M. (1988). *Consequences of adolescent drug use: Impact on the lives of young adults*. Sage Publications, Inc.
- Newcomb, P. A., & Carbone, P. P. (1992). The health consequences of smoking: Cancer. *Medical Clinics of North America*, 76(2), 305-331.

- Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, 16(1), 1609406917733847.
- Nutbeam, D. (2000). Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International*, 15(3), 259–267.
- O'Fallon, L. R., & Dearry, A. (2002). Community-based participatory research as a tool to advance environmental health sciences. *Environmental Health Perspectives*, 110(2), 155-159.
- Ohmer, M. L. (2007). Citizen participation in neighborhood organizations and its relationship to volunteers. *Social Work Research*, 31(2), 109-120.
- Ohmer, M. L., Teixeira, S., Booth, J., Zuberi, A., & Kolke, D. (2016). Preventing violence in disadvantaged communities: Strategies for building collective efficacy and improving community health. *Journal of Human Behavior in the Social Environment*, 26(7-8), 608-621.
- Osofsky, J. D. (1995). The effect of exposure to violence on young children. *American Psychologist*, 50(9), 782.
- Ousey, G. C. (2017). Crime is not the only problem: Examining why violence & adverse health outcomes co-vary across large U.S. counties. *Journal of Criminal Justice*, 50, 29-41.
- Pastore, D. R., Fisher, M., & Friedman, S. B. (1996). Violence and mental health problems among urban high school students. *Journal of Adolescent Health*, 18(5), 320-324.
- Pearce J., Witten, K., & Bartie, P. (2006). Neighbourhoods and health: A GIS approach to measuring community resource accessibility. *Journal of Epidemiology & Community Health*, 60(5), 389-395.
- Phelan, J., Link, B. G., Moore, R. E., & Stueve, A. (1997). The stigma of homelessness: The impact of the label "homeless" on attitudes toward poor persons. *Social Psychology Quarterly*, 60(4), 323-337.
- Plichta, S. B. (2004). Intimate partner violence and physical health consequences: Policy and practice implications. *Journal of interpersonal violence*, 19(11), 1296-1323.
- Rankin, B. H. & Quane, J. M. (2000). Neighborhood poverty and the social isolation of inner-city African American Families. *Social Forces*, 79(1), 139-164.
- Raphael, D. (2006). Social determinants of health: Present status, unanswered questions, and future directions. *International Journal of Health Services*, 36(4), 651-677.

- Reutter, L. I., Stewart, M. J., Veenstra, G., Love, R., Raphael, D., & Makwarimba, E. (2009). "Who do they think we are, anyway?": Perceptions of and responses to poverty stigma. *Qualitative Health Research*, 19(3), 297-311.
- Roeloffs, C., Sherbourne, C., Unützer, J., Fink, A., Tang, L., & Wells, K. B. (2003). Stigma and depression among primary care patients. *General Hospital Psychiatry*, 25(5), 311-315.
- Sampson, R. J. & Wilson, W. J. (2013). *Great American city: Chicago and the enduring neighborhood effect*. Chicago: University of Chicago Press.
- Sampson, R. J., & Groves, W. B. (1989). Community structure and crime: Testing social-disorganization theory. *American Journal of Sociology*, 94(4), 774-802.
- Sampson, R. J., & Raudenbush, S. W. (1999). Systematic social observation of public spaces: A new look at disorder in urban neighborhoods. *American Journal of Sociology*, 105(3), 603-651.
- Sampson, R. J., Morenoff, J. D., & Earls, F. (1999). Beyond social capital: Spatial dynamics of collective efficacy for children. *American Sociological Review*, 64(5), 633-660.
- Sampson, R. J., Raudenbush, S. W., & Earls, F. (1997). Neighborhoods and violent crime: A multilevel study of collective efficacy. *Science*, 277(5328), 918-924.
- Sampson, R. J., Raudenbush, S. W., & Earls, F. (1998). *Neighborhood collective efficacy: Does it help reduce violence?* Washington, DC: U.S. Dept. of Justice, Office of Justice Programs, National Institute of Justice.
- Sapat, A., Schwartz, L., Esnard, A. M., & Sewordor, E. (2017). Integrating qualitative data analysis software into doctoral public administration education. *Journal of Public Affairs Education*, 23(4), 959-978.
- Saridi, M., Kordosi, A., & Souliotis, K. (2015). The health system's and the state's approach to mental illness and stigma. *International Journal*, 8(2), 478.
- Schnittker, J., & John, A. (2007). Enduring stigma: the long-term effects of incarceration on health. *Journal of Health and Social Behavior*, 48(2), 115-130.
- Sharac, J., McCrone, P., Clement, S., & Thornicroft, G. (2010). The economic impact of mental health stigma and discrimination: a systematic review. *Epidemiology and Psychiatric Sciences*, 19(3), 223-232.
- Shedler, J., & Block, J. (1990). Adolescent drug use and psychological health: A longitudinal inquiry. *American Psychologist*, 45(5), 612.

Springer, K. W., Sheridan, J., Kuo, D., & Carnes, M. (2007). Long-term physical and mental health consequences of childhood physical abuse: Results from a large population-based sample of men and women. *Child Abuse & Neglect*, 31(5), 517-530.

Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, 17(10), 1372-1380.

Tauber, A. I. (2002). Medicine, public health, and the ethics of rationing. *Perspectives in Biology and Medicine*, 45(1), 16-30.

Thornton, L. E., Pearce, J. R., & Kavanagh, A. M. (2011). Using Geographic Information Systems (GIS) to assess the role of the built environment in influencing obesity: A glossary. *International Journal of Behavioral Nutrition and Physical Activity*, 8(71).

Tigges, L. M., Browne, I., & Green G. P. (1998). Social isolation of the urban poor: Race, class, and neighborhood effects on social resources. *The Sociological Quarterly*, 39(1), 54-77.

Tjaden, P. G., & Thoennes, N. (2000). *Extent, nature, and consequences of intimate partner violence*. National Institute of Justice Report. U.S. Department of Justice.

U.S. Census Bureau. (2018). How the U.S. Census Bureau measures poverty. Retrieved online on November 22, 2018 from <https://www.census.gov/topics/income-poverty/poverty/about.html>

U.S. Department of Health and Human Services. (2004). The health consequences of smoking: A report of the Surgeon General.

U.S. Department of Health and Human Services. (2014). The health consequences of smoking—50 years of progress: a report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 17.

Visser, M., Scholte, M., & Scheepers, P. (2013). Fear of crime and feelings of unsafety in European countries: Macro and micro explanations in cross-national perspective. *The Sociological Quarterly*, 54(2), 278-301.

Wallerstein, N., & Duran, B. (2010). Community-based participatory research contributions to intervention research: the intersection of science and practice to improve health equity. *American Journal of Public Health*, 100(1), 40-46.

Waxman, C. I. (1977). *The stigma of poverty; a critique of poverty theories and policies*. New York, NY: Pergamon Press.

Wilkinson, R. G., & Marmot, M. (Eds.). (2003). *Social determinants of health: The solid facts*. Copenhagen, Denmark: World Health Organization, Regional Office for Europe, WHO Centre for Urban Health (Europe) & International Centre for Health and Society.

Wilkinson, S. (1998). Focus group methodology: A review. *International Journal of Social Research Methodology*, 1(3), 181-203.

Wilson, D. R. (2010). Health consequences of childhood sexual abuse. *Perspectives in Psychiatric Care*, 46(1), 56-64.

Wilson, W. J. (1987). *The truly disadvantaged: The inner city, the underclass, and public policy*. Chicago, IL: University of Chicago Press.

World Health Organization, & WHO Global Consultation on Violence and Health. (1996). *Violence: A public health priority: WHO global consultation on violence and health*, Geneva, 2-3 December 1996. Geneva, Switzerland: World Health Organization.

World Health Organization, & WHO Global Consultation on Violence and Health. (1996). *Violence: A public health priority: WHO global consultation on violence and health*, Geneva, 2-3 December 1996. Geneva, Switzerland: World Health Organization.

Contributors

Stan Korotchenko is a doctoral candidate in the Public Affairs (PAF) Doctoral Program, Criminal Justice Track, at the University of Central Florida where he uses his diverse legal background and law practice experience to teach such courses as prosecution and adjudication, criminal law, and comparative justice systems. His research interests include juvenile delinquency and victimization as well as policy assessment and program evaluation in criminal justice.

Kim Anderson, Ph.D., LCSW, is a professor in the School of Social Work (SSW) and the Public Affairs (PAF) Doctoral Program at the University of Central Florida where she teaches clinical practice and evaluation courses, qualitative methods, social inquiry and public policy. Dr. Anderson has extensive experience in blending academic and applied research to bridge the gap between scholars and practitioners with empirical results that are accessible to diverse audiences.