“THE NUMBERS DON’T WORK FOR US:” AN ALTERNATE MODEL OF FUNDAMENTAL CAUSALITY FROM THE PERSPECTIVES OF AFRICAN AMERICANS IN URBAN ATLANTA

by

Yanique Alicia Redwood

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
(Health Behavior and Health Education)
in The University of Michigan
2008

Doctoral Committee:

Professor Barbara A. Israel, Chair
Associate Professor Mieko Yoshihama
Adjunct Assistant Professor Caroline Wang
Research Associate Professor Amy J. Schulz
Professor Marshall W. Kreuter, Georgia State University

© 2008 Yanique Alicia Redwood

To the residents of NPU-V (past and present) who are coping with harsh realities.

ACKNOWLEDGEMENTS

I remember vividly the day that I visited University of Michigan School of Public Health. It was the last stop on my tour of graduate schools to which I had been accepted. Unlike all the others, I immediately felt at home at UM-SPH, and like home, it was a place where I had many life changing experiences. I will never forget the people I met there who helped to usher me through the doctoral program.

I am first indebted to my dissertation committee members who truly supported my ideas and interests, while also providing the guidance and needed criticism to make my work stronger. I am indebted to Barbara Israel, who enthusiastically took on the task of being my chair. Barbara, thank you for the many helpful comments and suggestions, particularly early on as I was beginning to shape the direction of my research. I also appreciated your many words of encouragement, especially your emails that told me to "hang in there." I am also indebted to Amy Schulz. Amy, you encouraged me to stay closer and closer to what participants actually said, reinforcing the true meaning of "grounded" in grounded theory analysis. And then when it was time to insert my own voice, you encouraged me to do so as well. I am also thankful to Mieko Yoshihama for serving on my committee and providing helpful insights. Your suggestion that I explore the theory of structuration was especially helpful.

To Marshall Kreuter, you are such an inspiration. Thank you for helping to light a fire again about what could be possible through public health. You can never know how much your mentorship has meant. You can also never know what it meant to be your colleague while working on Accountable Communities: Healthy Together, the umbrella project for this dissertation study. Thank you for serving on my committee.

To Caroline Wang, thank you for calling me when I started graduate school and asking if I would be interested in working with you on a Photovoice project. The experience of Photovoice has ended up being one of those life changing experiences, and I am forever grateful to you for that. Thank you for your mentorship and friendship during challenging times in my life and career. When I wasn't so convinced that I could make a difference through research, you encouraged me to think about it some more. It was after that conversation at APHA 2004 that I decided to give it one more try. Thank you also for serving on my committee.

To other mentors along the way, I am also thankful to you. To Joan Sokolovsky, I don't know where you are right now, but you were the one who introduced me to public health and the Tuskegee Study in your Sociology of Medicine class at Georgia Tech. I had no idea that the field of public health existed. Thank you for mentoring me through my first painful struggles with issues of race, class and health. To Rueben Warren, thank you for introducing me to the mechanics of public health during my internship with you at the Agency for Toxic Substances and Disease Registry at the Centers for Disease Control and Prevention. Thank you for my first lessons on how to conduct research and write scientifically. Thank you also for helping me to decide on a graduate school that would nurture me as an African-American scholar.

Arline Geronimus, you changed my life and career when you challenged my class and religious biases that day in your office. I am not sure if you remember, but I will never forget. Your writings and teachings inspire me to think more critically about the lives of poor African Americans even in the face of widely held beliefs in the dominant culture. I also thank you and Sherman James for the weathering and John Henryism hypotheses and what they have taught me about alternate ways of viewing the sources of poor health outcomes for people of color with limited resources. I am grateful that I was able to hear them described directly by you. To Cleopatra Caldwell and Harold Neighbors, thank you for your support and encouragement.

To friends I have made along the way—Sawsan Abdulhrahim, Renee Bayer, Keren Charles, Darrell Hudson, Rodney Lyn, Susan Morrel-Samuels, Bola Odunlami, Jay Pearson, Michelle Segar, Aviva Simonte, Carla Stokes, Edna Viruelle-Fuentes, and Naima Wong—I am grateful for the times that we spent sharing ideas about community-based participatory research, social issues affecting people of color, and/or the dissertation process.

To the many people who live in NPU-V who have allowed me into their community. Thank you for sticking with me even when times were rough. This community-based participatory research work is tough, isn't it? But, it is also rewarding! Thank you for inviting me into the intimate aspects of your lives—birthday parties, doctor's offices, baby showers, weddings, funerals, and reunions. You are now a part of my life story (and hopefully I am also a part of yours) in a special place known as NPU-V.

To those ancestors who have gone before me, I draw strength from your struggles to create families, communities, and preserve culture after you were taken from the shores of Africa and brought to Jamaica, other parts of the Caribbean, and the Americas. To my family, there is none like you. It's so good to know that I have family all over the world rooting me on. To my parents, you have worked so hard to raise me and my sisters. The transition from Jamaica to the United States was not easy, so I appreciate all that you have done. Mom, thank you for your undying love and support. My godmother Aunt Sheila, I send a special thanks to you for all of your support over the years. Aunt Karen, thank you for helping me to design my explanatory model. To my sisters, you are my inspiration! I hope you know how much I admire you. My best friend Tammy, you are just like family. Thanks for being patient with my uneven phone calls because I had no time to talk. Let the conversations begin again!

Alana, thank you for allowing this education to have so much of me. You have been most patient and understanding. You are the best daughter a mommy could want. I only hope that you get to do what you love, as I have. Believe me when I say that doors will open up in ways that you could never have imagined.

Finally, to my husband Ronnie, thank you for taking on so much so that I could have the time to write during the last few months of my dissertation. You are a God send. Thank you for learning a little about grounded theory so that I could talk to you about my intellectual struggles. And thank you for being in the struggle with me for the betterment of the lives of our people. You have taught me about what it means to be a researcher-activist. I am grateful for you and our son, Darren, and the life that we all have together.

TABLE OF CONTENTS

DEDICATION **ii**

ACKNOWLEDGEMENTS **iii**

LIST OF TABLES **ix**

LIST OF APPENDICES **x**

CHAPTER 1 INTRODUCTION AND STUDY RATIONALE **1**

Problem Statement 1
Study Significance 3
Research Aims 4
Research Questions 5
My Orientation to the Research 5
Organization of the Dissertation 9

CHAPTER 2 LITERATURE REVIEW **11**

Racial/Ethnic Disparities in Health 11
Explanatory Perspectives 17
Community-Based Participatory Research 31
Photovoice 32
Grounded Theory 36

CHAPTER 3 METHODS **38**

Study Context 38
Collaboration 40
Extending Photovoice Usage 43
Sampling and Recruitment 45
Participant Demographics 48
Data Collection 49
Data Analysis 54
Member Checking 55

CHAPTER 4 STUDY RESULTS **56**

Research Question 1: What do Residents of NPU-V Perceive to be their Priority Health Concerns? 56
Research Question 2: What do Residents Identify as Factors that Contribute to Poor Health Outcomes? 70
Research Question 3: Through What Mechanisms do Residents Perceive that these Factors Operate? 77
Research Question 4: What do Residents Perceive as Potential Facilitators and Inhibitors of Improved Health Outcomes? 90
Research Question 5: What Strategies do Residents Use to Mitigate, Resist, or Undo the Effects of these Factors? 98
Summary of Results 102

CHAPTER 5 DISCUSSION **104**

Introduction 104
Overview of Explanatory Model 106
Model Components and the Related Literature 110
Summary of Explanatory Model 123
Strengths and Limitations 125
Validity 129
Implications for Public Health Research 129
Implications for Public Health Practice and Policy 133

CHAPTER 6 CONCLUDING REMARKS **136**

APPENDICES **140**

REFERENCES **171**

LIST OF TABLES

Table

1 Participant Demographics 49
2 Study Results 102

LIST OF APPENDICES

Appendix

A	Accountable Communities: Healthy Together Specific Aims	140
B	Type II Diabetes Prevalence (Females) Comparison GIS Map: NPU-V and NPU-F	141
C	Dirty Truth Campaign Description	142
D	SHOWeD Questionnaire	148
E	Dialogue Session Tracking Form	149
F	Demographic Data Collection Form	151
G	Participant Consent Form	152
H	Referenced Photographs	155

CHAPTER 1

Introduction and Study Rationale

Problem Statement

Murray, Kulkarni and colleagues (2006) defined eight Americas existing within the United States of America based on a combination of race, location of the county of residence, population density, race-specific county-level per capita income, and cumulative homicide rate. After comparing life expectancies across all eight subgroups, the researchers concluded that there are enormous disparities in mortality by all international standards across the eight Americas. For example, among young (15-44) and middle aged (45-64) adults, the mortality risk for Blacks living in high risk urban areas (America 8) are more similar to those in the Russian Federation and sub-Saharan Africa and are significantly higher than in America 1 (primarily Asian), Japan, or the United Kingdom. They found that 15-year old Black men and women in high-risk urban areas (America 8) were respectively, 3.8 and 3.4 times as likely as those in America 1 to die before the age of 60, and 4.7 and 3.8 times more likely as those in America 1 to die before the age of 45 (Murray, Kulkarni et al. 2006).

Unfortunately, these types of findings are neither new nor groundbreaking. Previous studies have documented excessive death rates for Blacks as compared to Whites in Harlem, Watts, central Detroit, and in the Black Belt area of Alabama (Geronimus, Bound et al. 1996), and estimated that Black men in Harlem in 1980 had

less chance of surviving to age 65 than men in Bangladesh (McCord and Freeman 1990). Youths disadvantaged on (male) gender, race, and urban poverty face as little as a 37% chance of surviving to age 65 (Geronimus, Bound et al. 2001). For persons advantaged on these dimensions, the chance of surviving to age 65 is approximately 90%. In addition to excessive death rates, African American men and women in high-poverty urban areas also have rates of health-induced disabilities at ages thirty-five and fifty-five that are comparable to the national averages for fifty-five and seventy-five year olds, respectively (Geronimus, Bound et al. 2001). At young adult ages, Black residents of poor localities face two to four times the disability prevalence as do Whites nationwide (Geronimus, Bound et al. 2001).

Preliminary data from the National Center for Health Statistics (2006) suggest that the leading causes of death in the United States in 2004 were heart diseases, cancer, stroke, chronic lower respiratory diseases, accidents and diabetes with African Americans (and other minorities) bearing a disproportionate burden of these leading causes of death. For example, the age-adjusted death rates for heart disease and stroke were 30% and 40% higher for African Americans than for Whites, respectively. Other analyses that compare mortality rates over time show that the age-adjusted all-cause mortality for all Blacks in 1998 (6.9 per 100,000) equaled the White value in 1969 (a 29-year lag) (Levine, Foster et al. 2001). Because of these differences in mortality rates, approximately 100,000 Blacks die each year who would not have died if disparities did not exist (Levine, Foster et al. 2001).

Despite the number of dollars that have been allotted for the elimination of health disparities, differences in health outcomes by race/ethnicity persist (Levine, Foster et al.

2001). One of the most important yet challenging aspects of eliminating racial and ethnic inequities is explaining why these differences exist (Griffith, Moy et al. 2006). Several perspectives have been offered to explain these differences and are the basis for public health interventions and programs. Key perspectives include the racial-genetic perspective, the health behavior perspective, the socioeconomic perspective, and the psychosocial stress perspective (see Dressler, Oths, et al. for a recent review of these perspectives). In addition, the fundamental cause perspective (Link and Phelan 1995; Dressler, Oths et al. 2005) constitutes another approach to explaining health disparities. The literature is replete with debates regarding the plausibility of each perspective. In particular, strong arguments exist on both sides for the socioeconomic perspective.

Racial and ethnic disparities in health continue to shape the life expectancy and quality of life for African Americans, in particular those African Americans living in poor urban communities. While academicians and scientists can contribute to our understanding of health disparities, there are a limited number of explanatory models grounded in the lived experiences of those populations with greater levels of disease and disability. In order to decrease and, ultimately, eliminate longstanding racial and ethnic disparities in health, there is a need for studies that investigate the fundamental causes of these disparities from the perspectives of those experiencing disparate health outcomes.

Study Significance

Health disparities have been well described and well documented, but not well addressed (Griffith, Moy et al. 2006), and according to a study by Levine, Foster and colleagues (2001) disparities in health between Black and White Americans are expected

to widen. The perspectives that have been offered to explain these disparities have various limitations, which will be described in the literature review. The racial-genetic perspective is generally not supported in the literature (Cooper 1984; Kaufman 1995; Cruickshank, Mbanya et al. 2001; Krieger 2003), while the health behavior (Bell, Adair et al. 2004), socioeconomic (Geronimus 2000; Adler and Newman 2002; Brawley 2002; Krieger, Chen et al. 2005) and psychosocial stress perspectives (James 1994; Krieger and Sidney 1996; Geronimus, Bound et al. 1999; Williams, Neighbors et al. 2003; Schulz, Gravlee et al. 2006), which have been tested empirically, appear to explain some of the disparities. The fundamental cause perspective (Link and Phelan 1995) is promising because it suggests that there may be factors, including socioeconomic status, contributing to racial/ethnic disparities in health that lie further upstream. Some of these factors are still unidentified and untested.

The purpose of this dissertation is to use the perspectives of those who directly experience racial and ethnic disparities as the primary source of input to elucidate additional fundamental causes and create an explanatory model to guide development of interventions at the individual, community, and policy levels.

Specific Aims

I. To gain an increased understanding of the health outcomes that African-American residents of an urban neighborhood face and their perceptions of the underlying factors that contribute to these poor health outcomes.

II. To incorporate these underlying factors into a model of fundamental causality that describes the relationships between these factors and the health outcomes of interest.

Research Questions

The overarching research question guiding this study is: "What are the fundamental causes of poor health outcomes from the perspectives of African-Americans in urban Atlanta?" Related research questions are:

1. What do residents of an urban neighborhood perceive to be their priority health concerns?
2. What do residents identify as factors that contribute to poor health outcomes?
3. Through what mechanisms do residents perceive that these factors operate?
4. What do residents perceive as facilitators and inhibitors of improved health outcomes?
5. What strategies do residents use to mitigate, resist, or undo the effects of these factors?

My Orientation to the Research

Although I am of Afro-Caribbean (Jamaican) descent, I strongly identify as an African American, which at times places me at odds with some Caribbeans who perceive that the health and social issues faced by African Americans result from their own lack of

work ethic and moral values. I have never held these beliefs, yet I was unable to escape their influence over the research questions I began asking when I started graduate school in 1998. I had recently, through social science coursework at my undergraduate science and engineering institution, learned of the Tuskegee Study and the field of public health and had come to the discipline pledging to ensure responsibility in research.

In one of my first papers in graduate school, I had proposed to analyze the difference between rates of childbearing for African Americans versus Whites in an effort to propose solutions to the problem of non-marital childbearing. Because of her expertise in this area of research, I sought advice from Dr. Arline Geronimus, a professor at the University of Michigan School of Public Health. My discussion with her was painful from many perspectives. She challenged my worldview and the class and religious biases that I had brought to the research, made more painful by the fact that she was White and I, African American. Although I wrestled for months after that discussion with my individual orientation to the problems faced by African Americans supported by both my Caribbean roots and the larger American ideals of fierce individualism, I soon found myself questioning the simple behavioral explanations that I had internalized, which prompted the exploration of a deep and complex literature about the structural forces that impact the health of African Americans and other minorities.

My orientation to this dissertation research, therefore, resonates with Link and Phelan's (1995) analysis of disparate health outcomes within the framework of "fundamental causes." As opposed to addressing the proximal indicators of poor health outcomes, Link and Phelan and others (Lieberson 1985; House, Kessler et al. 1990) propose that the public health field go further upstream to address more fundamental

causes, in particular socioeconomic status. Link and Phelan (1995) also propose that gender and race/ethnicity be considered as well, not because of any genetic predisposition held by women or minorities, rather the social marginalization that is often experienced by women and minorities. Because of this orientation to my dissertation research, I have had to balance my own structural-level perspectives with the perspectives of the participants in this study, who at times talked at length about individuals' capacities to solve their own social problems and at other times the community's responsibility for its own blight and levels of crime. This structural-level perspective that I have also shaped my analysis of the data and the model that I ultimately developed. Unlike many models that exist in the public health literature, the model that I developed does not include any individual-level mechanisms or conditions, such as the impact of individual attitudes and beliefs on an individual's exercise patterns. I attempted to create a model that shifted the focus away from individual-level risk factors toward more fundamental causes.

I also bring to this research a sense of urgency about the disparities in health facing African Americans. It was this urgency that preceded my departure from academia in 2001. At the time, research seemed slow and self-interested. I recall discussions with classmates prior to my departure about the importance of generating knowledge for the sake of knowledge, conversations which confirmed that I had little interest in generating knowledge if it did not practically affect the health and quality of life of study participants. Since then I have found a way through community-based participatory research to generate knowledge *and* work within communities to act upon the problems that they face. However, the urgency still remains.

Throughout the process of writing my dissertation, I had a working title that was based on a quote by Fannie Lou Hamer—"All my life I've been sick and tired. Now, I'm sick and tired of being sick and tired." Hamer, a prominent civil rights activist who died in 1977 from breast cancer and complications related to jailhouse beatings, uttered these now famous words to express her exhaustion about the conditions under which she and other African Americans lived. I borrowed these words to express my frustration with persisting inequalities in health as well as the frustration of residents in poor neighborhoods like the one that is the focus of this study. I also used these words to express the sentiment in the literature that health disparities have been well described and well documented, but not well addressed (Griffith, Moy et al. 2006).

Ultimately, I changed the title to reflect the words of participants in this study (described in more detail in chapter six); however, this quote by Fannie Lou Hamer was a very important frame for me throughout the writing process. This quote was a constant reminder of the suffering created by health disparities and the need to push the boundaries about what constitutes poor health and how we define the intervening pathways toward poor health outcomes. My sense was that people who experience the negative effects of health disparities would be in the best position to help me to push those boundaries. I knew that my privileged social status would not allow me to fully understand fundamental causes in the way that some people in our society understand them because they must contend with them everyday. These privileges also created power differentials that I and participants in this study constantly negotiated. Part of this negotiation sometimes involved listening while quieting my own voice so that the voices of those who have been marginalized could be brought into the conversation. At other

times, this negotiation meant that I introduced my own framing based on my education and training. For example, although residents did not always speak to the differences between their own and others' health outcomes, there is a rich literature on the differences between the health and social outcomes of African Americans and Whites. So, at times I made the assumption that participants were discussing disparities even if they did not say so explicitly given that the literature informs me that a poor health or social outcome in a poor African-American neighborhood will not be present to the same extent in more affluent White neighborhoods.

I firmly believe that it is this negotiation and integration of perspectives that is needed in research. As a researcher, I do not have all the answers. Neither do the participants in this study have all the answers. But, together we worked to create an alternate model of fundamental causality that can be used to guide research and policy with the effect of closing the gap in health disparities between African Americans and Whites.

Organization of the Dissertation

The next chapter of this dissertation is a review of the health disparities literature and the explanatory perspectives that have been proposed to explain differences in health outcomes between African Americans and Whites. In chapter two, I also provide a summary of the literature on community-based participatory research, the Photovoice methodology, and the grounded theory approach to qualitative data analysis. Study methods are described in chapter three and include a discussion of sampling, recruitment, data collection and analysis, and member checking. In chapter four, I present the results

from the study. This chapter includes a discussion of themes and responds to the study's research questions. In chapter five, I present an explanatory model that was generated based on the research results to explain fundamental causes of health disparities rooted in the perspectives of residents in this study area. Validity is also discussed along with implications for public health practice, policy, and research. In chapter six, I provide concluding remarks.

CHAPTER 2

Literature Review

In this chapter a review of the literature is provided on racial/ethnic disparities in health as it relates to African Americans, as well as the perspectives that have been offered to explain the existence of these disparities. Given the research approach used in this dissertation, in this chapter I also review the relevant literature on community-based participatory research, Photovoice, and grounded theory methodology. In keeping with a grounded theory approach, I will not include a conceptual model based on the reviewed literature. Rather, this review will serve to inform the development of an explanatory model presented in chapter 5 and grounded in the results of the study.

Racial/Ethnic Health Disparities

Paula Braveman (2006) defines a health disparity as a particular type of potentially avoidable difference in health or in the most important influences on health that could potentially be shaped by policies; it is a difference in which disadvantaged social groups (such as the poor, racial/ethnic minorities, women, or other groups that have persistently experienced social disadvantage or discrimination) systematically experience worse health or greater health risks than more advantaged groups. In this definition, Braveman challenges and simultaneously extends the meaning of disparity, a word that simply means difference. What Braveman and others (Whitehead 1992) argue

is that disparities in health are not indiscriminate. These differences occur because poor health systematically afflicts those who occupy the lower ranks of the social hierarchy. When framed in this way, health becomes a human rights issue. Human rights are rights that people ought to have regardless of how they are positioned in the social hierarchy (United Nations 1947). For this reason, some scholars argue that health inequity or health inequality are more appropriate terms to describe health differences because inequity implies that these differences are avoidable, unjust, and unfair (Whitehead 1992). In this dissertation, the term health disparity will be used to remain consistent with the literature in this area of study; however, its definition here is coterminous with Braveman's definition above.

With the exception of a few health outcomes (e.g., suicide), African Americans consistently exhibit higher rates of disease, disability, and mortality than their White counterparts at virtually every level of socioeconomic status (Geronimus, Bound et al. 2001). Kumanyika and Morssink (2006) argue that this focus on excess death and disability when framing health disparities detracts from a more holistic population health framework because of its concentration on individuals. However, Kumanyika and Morssink (2006) acknowledge that mortality and morbidity data can 1) provide evidence of inequities that is politically powerful and 2) mobilize resources to address disparities. For these reasons, this review will include mortality and morbidity data.

Poorer health outcomes for African Americans compared to Whites have been consistently documented in the literature and are evident across multiple diseases and across time. The fundamental cause perspective suggests that although disease specific mortality may change over time as humans learn how to avoid risk, disease, and their

consequences, all-cause mortality disparities will continue to persist if the fundamental causes of health disparities remain the same. For example, a study by Satcher and colleagues (2005) revealed that although rates of survival for both Blacks and Whites improved between 1960 and 2000, the standardized mortality ratio (SMR) has remained flat between Blacks and Whites. The SMR for Blacks was 1.472 in 1960. In 2000, it was 1.412, indicating that Blacks suffered 41.2% more deaths than would be expected if they experienced the mortality rate of Whites. Similarly, Murray and colleagues (2006) support the existence of stable disparities. Their study of eight subgroups in American society ("the eight Americas") defined by a combination of race and other data indicates that neither the relative ordering nor the absolute levels of life expectancy disparities among the eight Americas decreased between 1982 and 2001. These stable disparities in mortality and life expectancy translate into a startling number of lives lost. Woolf and colleagues (2004) conclude that 886, 202 African American deaths could have been averted between 1991 and 2000 if the mortality rates of African Americans equaled that of Whites.

A study of disparities at the local level also reflects levels of disparities similar to those found at the national level. Geronimus, Bound and colleagues (2001) calculated population-level estimates of mortality, functional health status, and active life expectancy for adults living in 23 local areas in 1990 and for Blacks and Whites nationwide. They matched disadvantaged geographic areas with socio-economically better-off areas that were geographically proximate and matched on race. They found that, in general, African American residents of urban poor areas fare substantially worse than residents of other less poor areas. While the probability of surviving to age 65 was

61% for White men in Cleveland and 57% for White men in Detroit, the same probability for Black men in Harlem (37%), Central City Detroit (46%), South Side Chicago (40%), and Watts (46%) was much lower.

Another study (Geronimus, Bound et al. 1999) of four geographic areas (Harlem, Central City Detroit, South Side Chicago, and Watts) found that women in these areas experience the same or higher probability of death by age 55 as the typical White women does at 70. The findings for Harlem and Chicago are more severe with women in these two localities experiencing a higher probability of dying by age 40 than a White woman nationwide has of dying by age 60. For men in these four areas, the probabilities are slightly worse. Men in the local populations face approximately the same probability of dying by age 35 as White men nationwide face by age 60.

The top three causes and seven of the ten leading causes of death are shared by African Americans and Whites, yet African Americans bear a disproportionate burden of the risk factors, incidence, morbidity, and mortality associated with these diseases (MMWR 2005). To illustrate the extent of these disparities, the top two leading causes of death will be discussed.

<u>Heart Diseases</u>. Heart diseases accounted for 29% of all deaths in 2001 (NCCDPHP 2004). The rate of death due to heart disease was 31% higher for Blacks than Whites (NCCDPHP 2004). In 1950, this was not the case. Rates of death from heart disease were comparable for Blacks and Whites in 1950, but a rapid decline for Whites has resulted in greater disparities (Williams and Jackson 2005). Hypertension, which is a major risk factor for heart disease, is high among African Americans regardless of sex or educational status (Mensa, Mokdad et al. 2005). The age-adjusted

prevalence of hypertension was highest in Blacks (40.5%) compared with 27.4% in Whites (MMWR 2005).

Cancer. Cancer is the second leading cause of death for both Blacks and Whites. However, in 2001, the age-adjusted incidence per 100,000 population was substantially higher for Black females than for White females for certain cancers, including colon/rectal (54.0 versus 43.3), pancreatic (13.0 versus 8.9), and stomach (9.0 versus 4.5) cancers (MMWR 2005). Among males, the age-adjusted incidence was higher for Black males than for White males for certain cancers, including prostate (251.3 versus 167.8), lung/bronchus (108.2 versus 72.8), colon/rectal (68.3 versus 58.9), and stomach (16.3 versus 10.0) cancers (MMWR 2005). While rates of death due to heart disease were similar for Blacks and Whites in 1950, the cancer death rate in 1950 was actually lower for Blacks than Whites (Brawley 2002; Williams and Jackson 2005).

Although Blacks and Whites share the top three causes of death and seven of the ten leading causes, there are some important differences between the two groups in causes of death. For African Americans, HIV is the eighth leading cause of death and homicide is the sixth leading cause of death. Neither of these two conditions appear in the top ten causes of death for Whites. In some parts of the country, these two conditions rank among the top causes of deaths for African Americans. For example, HIV was the principal cause of excess death among Black men in Harlem and the second most common cause among Black women (Geronimus, Bound et al. 1996). Homicide was the leading cause of excess death among Black men in Watts and the second most common cause among Black men in Detroit (Geronimus, Bound et al. 2001).

Another important difference between Blacks and Whites is the relative impact of suicide. While suicide is the tenth leading cause of death for Whites, it does not appear in the top ten leading cause of death for Blacks. In general, suicide rates have been much lower for Blacks than Whites, a pattern that is consistent with the general finding of no Black-White differences in mental disorder (Neighbors and Williams 2001). Explanations for this paradox include higher religiosity and social support among African Americans, although these protective factors have not been tested empirically (Neighbors and Williams 2001). Recent studies point to increased prevalence of attempted suicide among Black young adults. Results from the Youth Risk Behavior Surveillance indicate roughly equal prevalence rates of actual suicide attempts for Black and White adolescents (7.6% and 7.3% respectively).

In 1985, the then Secretary of Health and Human Services Margaret Heckler stated in her own words this “sad and significant fact”: there is a continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our nation’s population as a whole (Heckler 1985). Twenty years later, the National Healthcare Disparities report (2006) paints a similar picture: disparities related to race, ethnicity, and socioeconomic status remain prevalent across many clinical conditions including cancer, diabetes, end stage renal disease, heart disease, HIV disease, mental health and substance abuse, and respiratory diseases. The stubborn existence of disparities has led to a number of efforts to close the gap including the Healthy People 2010 initiative, which has as one of its two major goals the elimination of disparities between African Americans and other population groups (2000). However, a study by Levine, Foster, et al. (2001), using historical data from the National Center for Health

Statistics and the Census Bureau and forecasting methodology, predicts that disparities in mortality and life expectancy are expected to increase regardless of whether inequality is measured by relative overall age-adjusted mortality, relative life expectancy, or lags in either measure and regardless of whether the 1940 or 2000 standard population is used for age adjustment. Krieger and Williams (2001) caution that the use of the 2000 standard population for age adjustment can demonstrate reductions in health disparities that are actually not present and recommends the use of consistent age standards for all comparisons.

Explanatory Perspectives

In response to the weight of evidence describing racial/ethnic disparities in health, several explanatory perspectives have been proposed. Five frequently cited perspectives are reviewed here including supporting and refuting evidence for each.

The Racial-Genetic Perspective

The racial-genetic perspective emphasizes that differences in the distribution of genetic variants best explains racial health disparities (Dressler, Oths et al. 2005). One of the more prominent hypotheses with a racial-genetic component is the slavery hypothesis (Wilson 1986; Grim 1988; Wilson and Grim 1991). The slavery hypothesis states that salt shortages in Africa contributed to a salt-sparing genetic variant exacerbated by salt deprivation during the Middle Passage for African Americans. Therefore, when salt is plentiful, African Americans retain more sodium, resulting in high blood pressure. In a scathing critique of this hypothesis, Curtin (1992) discredits the salt-shortage assumptions by pointing to the lack of historical evidence that these shortages existed.

Curtin (1992) also asserts that rates of hypertension on the continent of Africa would have also increased as salt became more available, which has not been proven by studies of Black populations in Africa as described below.

A study of Black populations in rural and urban Cameroon, Jamaica, and Britain point to the variation in rates of hypertension and diabetes as evidence that phenotype and blood pressure are not correlated (Cruickshank, Mbanya et al. 2001). A similar study of seven populations of West African origin also confirms variation in prevalence rates of hypertension with an observed step-wise gradient from Nigeria to the United States. The lowest rates of hypertension were found in Nigeria and rural Cameroon; the highest rates were found in the United States. Prevalence rates in the Caribbean were intermediate between Africa and the United States (Cooper, Rotimi et al. 1997). These studies show that environmental factors play an overwhelming role in these genetically similar populations, even if that similarity is not yet formally measured.

Sickle cell anemia, a single gene disorder which is more prevalent in African Americans, has been lifted as evidence of genetic differences between Blacks and Whites. However, sickle cell anemia has been found to be more related to geographic locations where there were higher prevalence rates of malaria than to race (Allison 1954). Cooper (1984) argues that even if sickle cell anemia were a genetically based disorder, it would be incorrect to assume transferability to other diseases such as cancer. In addition, sickle cell anemia accounts for only 0.3% of the excess deaths experienced by African Americans (Cooper 1984); therefore, its significance in creating disparities in health between Blacks and Whites is low in comparison to diseases such as heart disease and cancer. Other evidence that refutes the racial-genetic perspective is the fact that

differences between Blacks and Whites in deaths due to heart disease did not exist before 1950 (Brawley 2002; Williams and Jackson 2005). Due to the lengthy time scale on which genetic changes materialize, the significant growing disparity between Blacks and Whites in deaths due to heart disease within the past 60 years cannot be attributed to genetic changes.

Other scholars cite greater internal genetic diversity (Cooper, Rotimi et al. 1997); the untenable concept of race (Frank 2001; Freeman 2003; Krieger 2003); the miniscule contribution of physiological mechanisms to excess mortality (Kaufman, Cooper et al. 1997); the plethora of evidence supporting the impact of social and environmental influences (Sankar, Cho et al. 2004); and the lack of a consistent hypothesis linking diseases to African ancestry (Kaufman 1995) as additional evidence refuting the racial-genetic perspective.

The Health Behavior Perspective

Within the public health literature, health behavior perspectives are numerous and attempt to explain how individuals' attitudes, beliefs, and/or behaviors influence health outcomes (Dressler, Oths et al. 2005). An early Report of the Surgeon General (1979) suggested that approximately half of the mortality in 1976 was attributable to health behavior, 20% to environmental factors, 20% to biological factors, and 10% to inadequacies in health care. This finding was also supported by McGinnis and Foege (1993) in their analysis of the many proximal behavioral contributions to health disparities such as diet, tobacco use, and sexual activity. Applied within the context of racial/ethnic health disparities, differences between racial and ethnic groups in health outcomes are attributed to the greater distribution of poor individual health behaviors

among certain racial groups. For example, Schoenborn and colleagues (2004) reported that Black adults are less likely to be physically active than White adults (49.3% v. 63.5%) and more likely to be obese (30.4% v. 20.8%). Black women had particularly high rates of obesity compared to White women (34.9% versus 19.8%).

In a review of the health disparities literature, Dressler, Oths and colleagues (2005) respond to these data by citing a study by Bell, Adair, and colleagues (2004) showing elevated risk for hypertension for Black women even after controlling for physical activity and obesity. A study of ethnic differences in the prevalence of hypertension by Bassett, Futzhugh and colleagues (2002) found that Blacks were more likely to be hypertensive than Whites even after controlling for a combination of risk factors such as physical activity, socioeconomic status, sodium intake, smoking, alcohol intake, and BMI. Another study of the relationship between SES and health status also indicates that the behavioral risk factors of smoking, alcohol consumption, physical inactivity and overweight statistically account for only a small part of the increased risk of poor health status due to SES (Lantz, Lynch et al. 2001).

Health behavior perspectives do not appear to explain as much of the difference in mortality as once believed. In addition, health behavior perspectives tend to ignore the impact of racial and social disadvantage on the ability to practice healthy behaviors. Researchers who do attempt to frame health behaviors in terms of racial or social disadvantage suggest that being disadvantaged influences one's ability to practice healthy behaviors. Using a fundamental cause framework, Schulz, Zenk and colleagues (2005) suggest that one mechanism through which fundamental causes like race-based residential segregation operate is by limiting access to healthy foods and thus limiting the

ability to eat appropriate foods. Geronimus (2000), a proponent of fundamental causes such as poverty, suggests that generally and persistently difficult psychosocial conditions contribute to the increased tendency of the poor to engage in some unhealthy behaviors. Williams and Jackson (2005) also note that disadvantaged racial groups and those with low SES are less likely to reduce high risk behavior or to initiate new health-enhancing practices.

The Psychosocial Stress Perspective

As it relates to racial disparities in health outcomes, the psychosocial stress perspective emphasizes the stresses associated with minority group status, such as the experience of racism and discrimination (Clark, Anderson et al. 1999). For example, racism at the societal level can shape the socioeconomic opportunities, mobility, and life chances of minority groups (Williams, Yu et al. 1997), while experiences with race-based discrimination, both actual and perceived, can lead to physiological responses that contribute to disease and mortality (Williams, Yu et al. 1997). This review will focus on 1) stressors related to racism and discrimination and 2) the relationship between these stressors, perceptions of and responses to these stressors, and health.

In order to better understand the greater prevalence of hypertension in the Black US population than in the White US population, Krieger and Sidney (1996) drew on studies that suggest that suppressed anger may be a risk factor for hypertension. They found that among working-class Black women and men in their mid-20s to mid-30s, blood pressure was highest among those reporting having experienced no racial discrimination and lowest among those reporting discrimination in one or two of the specified situations. The authors conclude that internalized anger in the context of

limited resources may be the mechanism through which working class Blacks experience increased blood pressure supporting an earlier study by the same first author with similar findings (Krieger 1990). They also found that Black-White differences in systolic blood pressure would be reduced by 33% among working-class women and by 56% among working-class men if these Black women and men had the blood pressure of those reporting racial discrimination in one or two situations.

In a review of the literature on the relationship between discrimination and various health outcomes, Williams, Neighbors and colleagues (2003) find mixed results. Some studies find a positive association and others find a positive association under certain conditions. In general, discrimination was found to be associated with poor health status and was particularly robust for mental health. This general finding has been supported by a study of African-American women in Detroit (Schulz, Gravlee et al. 2006).

Although mental health is an important health outcome in its own right, studies have been designed to analyze mental health as a mechanism through which the stress of racism and discrimination can impact physical health. For example, the impact of mental health on hypertension has been studied as a possible mechanism through which stress (particularly the stress of discrimination) can impact health. Jonas and Lando (2000) used data from the NHANES I Epidemiologic Follow-up Study to determine the relationship between negative affect at baseline and subsequent hypertension. They found that high and intermediate affect at baseline was predictive of higher relative risk for subsequent hypertension for Black women compared to White women and all men. The authors cite a study by Musselman, Evans and colleagues (1998) that suggests

increased arousal and mobilization of energy stores seen in anxiety and depression may impact the development of hypertension by making the heart more reactive and that this increased arousal may be due to discrimination and/or resultant lack of autonomy associated with lower socioeconomic status. Likewise, Seeman and McEwen (1996) suggest that neuroendocrine reactivity may be related to greater risks of disease and disability. This link, known as allostatic load, refers to the cumulative strain on the body produced by repeated ups and downs of physiologic response as well as by the elevated activity of physiological systems under challenge (McEwen and Stellar 1993). Three hypotheses have been proposed to explain why, for Black Americans, there appears to be greater activation of these physiological responses.

James (1994) developed the John Henryism hypothesis to describe the tenacious active coping response to psychosocial stressors in the Black community. John Henryism is based on the legend of John Henry, the steel-driving man who beat a mechanical steam drill in a contest of man against machine and died after from complete physical and mental exhaustion. The John Henryism hypothesis assumes that lower socioeconomic status individuals in general, and African Americans, in particular, are routinely exposed to psychosocial stressors that require them to use considerable energy to manage these stressors. Those who respond with high-effort coping will have greater prevalence of hypertension.

In pilot tests of the John Henryism hypothesis, Blacks who scored high on a John Henryism scale had higher blood pressure and a higher prevalence of hypertension if they had fewer resources for achieving goals (James 1983; James 1987; James 1992) although not all findings were statistically significant. When African American samples were

stratified by SES such that the sample include high SES/low perceived stress individuals and low SES/high perceived stress individuals and further stratified by John Henryism, hypertension prevalence was significantly higher among low SES individuals who scored high on John Henryism (James 1992). A more recent review of the John Henryism literature reveals that tests of the John Henryism hypothesis with varying populations and outcome variables have produced mixed results (Bennett, Marcellus et al. 2004).

A similar framework has been proposed by Mullings (2006) to describe the multiplicative effects of class, race, and gender on health. Mullings (2006) posits that African American women are exposed to structural inequalities that position them such that they experience a particular constellation of stressful life experiences that have negative implications for their health. Named after Sojourner Truth, a slave who became an abolitionist preacher in the mid-1800s, the Sojourner Truth syndrome embodies many of the named struggles of Sojourner Truth: economic, household and community responsibility, working outside the home (like a man), and the constant need to address community empowerment along with the experience of exclusion from the protections of private patriarchy, the experience of being silenced, and the loss of children. Mullings (2006) proposes that this syndrome as a survival strategy may have both short-term and long-term benefits but it also has costs, including health consequences.

The weathering hypothesis is a similar framework, which has been tested empirically. The weathering hypothesis suggests that the effects of social inequality on the health of populations may compound with age leading to narrowing gaps in health status through young and middle adulthood that can affect fetal health (Geronimus, Bound et al. 1999). Findings from a test of this hypothesis indicated that maternal age is

statistically significantly related to the odds of low birth weight and very low birth weight for Black mothers but not White mothers and the relationship is stronger in low socioeconomic groups. The authors speculate that smoking behavior may be one mechanism that impacts the health of older mothers and suggest that smoking may be a response to psychosocial stressors. The authors also suggest that the structural sources of stress, the stress itself, or the physical toll of coping with stress may also be contributing factors.

Although the psychosocial stress perspective attempts to frame the psychological experience of stress in terms of socially determined stressors, by focusing on the impact of stress on physiological processes, this perspective positions research on racial/ethnic health disparities closer to proximal risk factors (e.g., smoking, coping responses) and away from the distal or fundamental factors associated with poor health outcomes, such as socioeconomic status.

The Socioeconomic Status Perspective

The socioeconomic status perspective suggests that the overrepresentation of some racial groups within lower socioeconomic statuses explains health disparities by race and that once there is accounting for SES, racial/ethnic differences are reduced or partially explained (Dressler, Oths et al. 2005). Studies that support this perspective point to a reduction in the magnitude of group differences after controlling for SES.

In 1977, the British government commissioned a report on health inequalities led by Sir Douglas Black (1980). That report (often referred to as the Black Report) pointed to social class as a major factor responsible for health disparities. Navarro (1990) asserts that the differential mortality rates between Blacks and Whites can be mostly explained

by class differentials between the two groups. The author presents results showing that the lower-income population represents 40% of the population, yet they only received 15.7% of the total income in 1984. By contrast, the wealthiest 20% of the population received 42.9% of the total income. Navarro (1990) argues that this growing disparity of wealth and income by class mainly, but not exclusively, explains the race differentials in morbidity and mortality.

Navarro is supported by other authors who concur that the relationship between health and poverty is one of the most robust findings of social epidemiology and drives health disparities more than any other factor (Geronimus 2000; Adler and Newman 2002; Bradley, Given et al. 2002; Brawley 2002; Freeman 2003). In an empirical study of the relationship between health disparities and socioeconomic factors, Krieger, Chen and colleagues (2005) defined socioeconomic status groups based on the percentage of persons in a census tract living below poverty level. The study results indicate that there are significant trends of increased risk for virtually all health outcomes by SES and that census track-level poverty substantially reduced the excess risk observed among Blacks compared to Whites. The authors argue that, unlike other European countries, the United States does not routinely collect information on socioeconomic status as it does for race/ethnicity, thus the net effect has been to remove from view the pervasive patterning of US health disparities by socioeconomic position.

Kawachi, Daniels and colleagues (2005) describe evidence that suggests that low-income Black Americans have more in common with low-income White Americans than with middle class or affluent Black Americans. However, the authors point to the drawback of this analysis of SES as a confounder of racial differences because race is an

antecedent to class and by controlling for SES, there may be overcontrolling for a large portion of the causal effect of race on health. Bonilla-Silva (1996) argues that controlling for SES neglects the obvious—why a group is underrepresented in certain categories of the control variables in the first place. Other critics of the SES perspective point to evidence that racial disparities still exist even after controlling for SES (Williams, Lavizzo-Mourey et al. 1994; Geronimus, Bound et al. 1996; Schulz, Zenk et al. 2005). Bell, Adair, and colleagues (2004) found that while SES was more strongly associated with hypertension in Blacks than Whites, Blacks were still 1.97 (95% CI 1.47–2.64) times more likely to have untreated hypertension than Whites after adjusting for SES differences. The authors also conclude that if there were no SES disparities between Blacks and Whites, and women from both racial/ethnic groups had high income and education levels, hypertension would still be almost twice as prevalent among Blacks (8.3% vs. 4.7% for Whites). Conversely, if all Whites had a low SES profile, as is the reality for a majority of US Blacks, only 11.1% would be hypertensive compared to 18.8% of Blacks (Bell, Adair et al. 2004).

These differences in racial disparities after accounting for SES at times leads researchers to conclude that inherent biological differences exist between Blacks and Whites. However, others have argued that the remaining difference is due to an incorrectly specified SES construct. Williams and Collins (1995) have argued that SES indicators such as income and education do not fully capture SES. For example, the construct of wealth, which may be a better indicator of SES is rarely used in research. Kaufman, Cooper and colleagues (1997) suggest that there is great variability between Blacks and Whites in SES indicators even when the two groups are categorized similarly.

For example, although an SES indicator may be percentage without a college education in a zip code, national data indicate that 27.1% of Blacks lacked a high school degree compared to only 18% for Whites. Therefore, even within the same category, Blacks and Whites may differ in SES. Kaufman, Cooper and colleagues (1997) also argue that SES measures are not commensurate between Blacks and Whites. For example, income levels for Blacks are lower at every level of education; Blacks pay more for equivalent housing, basic food costs, and other living costs; and Blacks have less median family net worth at similar levels of income. Krieger, Rowley and colleagues (1993) also argue that simple income and education measures cannot account for conditions such as differential exposure to environmental toxins, dangerous occupational conditions, and community-level stressors.

Kawachi, Daniels, and colleagues (2005) argue for the use of both race and class acknowledging that class mediates some of the relationship between race and health and that not all disparities by race follow the expected class pattern. For example, low birth weight increases with education for Black women. LaVeist (2005) also argues that although race and SES are correlated, it is clear that both are independent predictors. Although Geronimus (2000) advocates for poverty as a powerful factor in racial health disparities, in a subsequent article (Geronimus and Thompson 2004), she and co-authors argue that beyond the economistic assumptions about the impact of limited resources on health is the negative cultural ostracism that it represents. They argue that interventions that address the acquisition of income, education, or material goods alone will be insufficient to eliminate racial health inequality in a context where Whites see the

American economic system as fair and see Blacks as making excessive demands and blaming personal failures on the system.

The literature on the relationship between SES and racial/ethnic health disparities is extensive. Although the fundamental cause perspective also focuses on SES, Link and Phelan (1995) speculate that there are other, yet undiscovered, fundamental causes that shape the health outcomes of minority group members.

The Fundamental Cause Perspective

The fundamental cause perspective developed by Link and Phelan (1995) based on earlier work by House, Kessler and colleagues (1990) suggests that in order to significantly impact our progress toward eliminating health disparities, more emphasis must be placed on investigating the fundamental causes of disease. They note that social factors receive far less attention than proximate causes of disease such as diet, hypertension, and lack of exercise. In this way, the fundamental cause perspective attempts to focus on societal-level factors and their relationships to health outcomes. One of the strongest arguments in favor of the fundamental cause perspective is the persistence of disparities in health even though many of the factors that had been identified in the 1960s as linking SES to disease had been addressed (Link and Phelan 1995). Link and Phelan argue that risk factors can be eradicated, but as new ones emerge, people of higher SES are more favorably situated to know about the risks and to have the resources that allow them to engage in protective efforts to avoid them.

In some ways, the socioeconomic status perspective could be viewed as a sub-category of the fundamental cause perspective due to the heavy emphasis on SES as a fundamental cause of disease. In addition, Link and Phelan (1995) suggest that

race/ethnicity and gender should also be considered as fundamental causes because they are tied to resources like money, power, and prestige—a clear alignment with the socioeconomic perspective. Other attributes of a fundamental cause are its influence on multiple risk factors and multiple disease outcomes.

While the fundamental cause perspective became popular through the work of Link and Phelan, researchers before them have proposed similar frameworks (House, Kessler et al. 1990) with similar terminology, such as "basic" causes (Lieberson 1985). In addition, other researchers have proposed that macrosocial factors (Schulz and Northridge 2004); racism (Williams, Lavizzo-Mourey et al. 1994; Geronimus and Thompson 2004; Schulz, Zenk et al. 2005); and race-based residential segregation (Williams and Collins 2001; Schulz, Williams et al. 2002; Schulz, Zenk et al. 2005) are fundamental causes of racial disparities in health.

Link and Phelan (2005) reported the results of a test of fundamental causes by Phelan, Link and colleagues (1999). The authors hypothesized that if the utilization of resources is critical to prolonging life, then in circumstances when resources associated with higher SES are useless, high SES should confer little advantage and the usually robust SES-mortality association should be reduced. Consistent with these predictions, the SES-mortality association was found to be much stronger for highly preventable causes of death than for less preventable causes. It is precisely because racial/ethnic health disparities are preventable that there is a need to better understand and address fundamental causes.

The fundamental cause perspective promises much in terms of shifting the focus away from individual risk factors toward macrolevel factors particularly with its

emphasis on the role of socioeconomic status. However, in addition to SES, given the complexities of the determinants of health (as reviewed above), there is a need for additional conceptualizations of fundamental causes.

Community-Based Participatory Research

Community-based participatory research (CBPR) is a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings (Israel, Schulz et al. 1998). CBPR begins with a research topic of importance to community members with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities (Minkler and Wallerstein 2003). Unlike traditional approaches to research, in which an outside researcher emphasizes the discovery of facts that can be scientifically established through experimental methods (Crotty 1998), CBPR is an approach to research that challenges notions about 1) who conducts the research, 2) the types of questions that are asked, and 3) to what end the research is conducted. Minkler and Wallerstein in describing CBPR quote Gaventa (1981) who states that participatory approaches blur the line between the "researcher" and the "researched." As such, CBPR attends to issues of power between the researcher and people in communities and acknowledges that research is a co-learning process (Israel, Schulz et al. 2003) in which both parties contribute to the creation of knowledge. In addition, people in communities participate in defining the research agenda and the ultimate goal of the agenda, which, from the community's perspective, often involves some sort of action or intervention. This attention to power, co-learning, and action is consistent with some of the key

principles of CBPR—CBPR facilitates collaborative, equitable partnership in all phases of the research, CBPR promotes co-learning and capacity building among all partners, and CBPR integrates and achieves a balance between research and action for the mutual benefit of all partners (Israel, Schulz et al. 2003).

The rationale for using a CBPR approach is based on another key principle of CBPR—its emphasis on the local relevance of public health problems and ecological perspectives that recognize and attend to the multiple determinants of health and disease (Israel, Schulz et al. 2003). Because this dissertation study attempts to understand what residents of a local geographic area believe are important health concerns and the fundamental causes of those health concerns, the CBPR approach is applicable. In addition, racial and ethnic disparities in health have been linked to social and economic marginalization (Navarro 1990; Geronimus 2000; Williams and Collins 2001; Williams and Jackson 2005), issues that are central to the CBPR approach.

Photovoice

Photovoice is a qualitative research methodology that involves providing cameras to community people to record their own health realities followed by small-group discussions about their photographs. Community people then present their images and stories in large community forums in order to influence policymakers to make health-promoting decisions (Wang 1999). Photovoice is not only a qualitative research methodology, but it also embodies many of the principles of CBPR in that community members engage in a process whereby they define issues of importance to them and are empowered to intervene at the policy level by presenting their pictures and stories to

decision-makers. It is important to note that even participatory methodologies are not intrinsically empowering; rather the intentional use of the methodology consistent with the principles of CBPR can be empowering.

Photovoice was created by Wang and Burris (1996) and was first used by village women in Yunnan Province, China. In developing countries, rural women are often neither seen nor heard, despite their extraordinary contribution to the labor force (Wang, Burris et al. 1996); therefore, the three main goals of this Photovoice project were to empower rural women to record and reflect their own lives, to increase collective knowledge about women's health status, and to inform policymakers and the broader society about health and community issues of great concern and pride. Out of this project emerged several photographs related to reproductive health and childcare which were subsequently used to inform social policy. Since then, Photovoice has been used with diverse populations to address a number of public health concerns. Examples include use by a state maternal and child health agency as a needs assessment tool in an area with high percentages of low birth weight births, infant mortality, and late or no entry into prenatal care (Wang and Pies 2004); with a homeless population residing in shelters in Washtenaw County, Michigan (Wang, Cash et al. 2000); with youth affected by HIV in the San Francisco Bay area; with youth and adults addressing broad-based community concerns in Flint, Michigan (Wang, Morrel-Samuels et al. 2004); and with rural African American breast cancer survivors in North Carolina (Lopez 2002).

The Photovoice methodology is grounded in three theoretical perspectives: 1) empowerment education, 2) feminist theory, and 3) documentary photography, each of which is described below.

Empowerment Education

The work of Paulo Freire provided the basis for the development of the Photovoice methodology. Freire (1970) contended that every human being, no matter how “ignorant” or submerged in the “culture of silence,” is capable of looking critically at the world in a dialogical encounter with others. According to Freire’s approach, education is the key to empowerment as it facilitates the process of critically analyzing social, political, and economic relations. Freire (1970) also noted that:

> *“To exist, humanly, is to name the world, to change it… If it is in speaking their word that people, by naming the world, transform it, dialogue imposes itself as the way by which they achieve significance as human beings… Because dialogue is an encounter among women and men who name the world, it must not be a situation where some name on behalf of others” (88).*

Feminist Theory

Maguire (1987) has noted that even though Freire was concerned with oppressed groups, his writings ignored the domination of women by men. It is, therefore, symbolic that Photovoice was first used by women. However, the use of the Photovoice methodology is not limited to women. Photovoice includes women, and extends beyond them to involve other oppressed groups in participatory research. Feminist theory suggests that power accrues to those who have voice, set language, make history, and participate in decisions (Smith 1987). Therefore, feminist theory in the context of Photovoice is related more to balancing power between oppressed and oppressor as opposed to advocating for specific women’s rights. In addition, feminists have criticized the positivist assumption that objectivity exists in the research process (Wang, Burris et al. 1996). Photovoice, and methods like it, don’t claim to be objective. Rather, they

establish the validity of the subjective experiences of people who are often not represented or ill-represented.

Quoting from Wang, Morrel-Samuels and colleagues (2004), Photovoice draws from a position in feminist theory described by art historian Griselda Pollock (1996):

> *"Everyone has a specific story, a particular experience of the configurations of class, race, gender, sexuality, family, country, displacement, alliance. . . . Those stories are mediated by the forms of representation available in the culture" (XV).*

Documentary Photography

The use of documentary photography to promote social change is not a new concept, and much of the history of documentary photography involves professional photographers taking pictures of marginalized people. However, Photovoice takes a different approach in that people who typically have been the subjects of photographs use cameras to capture images that reflect their own everyday realities. As told by Dr. Wang and paraphrased for inclusion here:

> *In the Yunnan project, there was a photograph of a rice field with a black speck surrounded by several rows of green stalks. A professional photographer on the project encouraged the woman to next time get closer to her subject (the black speck was another woman in the field). She responded with, "I want to show that this one woman is responsible for this entire field of rice."*

This exchange is an example of how a professional's view can differ from a local person's view, and that local people are in the best position to represent their own lives. In addition, local people have access to their surroundings in a way in which an outsider does not.

Grounded Theory

Grounded theory methods provide systematic procedures for shaping and handling rich qualitative materials although they may also be applied to quantitative data (Glaser and Strauss 1967; Charmaz 1994). The centerpiece of a grounded theory research approach is the development or generation of a theory closely related to the context of the phenomenon being studied (Creswell 1998). Through systematic coding, phenomena are named and described followed by a process whereby relationships between codes are defined. These relationships between the codes form the basis for the development of hypotheses and ultimately a grounded theory or model.

The first level of coding is known as open coding and is an attempt to define what is happening in the data (Charmaz 1994). Open codes remain close to the data and are used to label phenomena, often line by line or incident by incident. Other types of codes are called in vivo codes, which are phrases used by informants themselves that are catchy and immediately draw your attention to them (Strauss and Corbin 1990). In vivo codes are similar to line by line codes because they encourage the researcher to remain close to the text. The next level of coding is known as axial coding, a process by which the data are reassembled into categories and subcategories and the relationships between them determined (Strauss and Corbin 1990). A category is a central idea, event, happening, or incident. Subcategories include the context in which the category is embedded, the action/interactional strategies by which it is handled or managed, and the consequences of those strategies (Strauss and Corbin 1990). Selective coding is the final process of selecting a core category and systematically relating it to other categories to develop a model or theory that is grounded in participants' perspectives (Strauss and Corbin 1990).

Although presented here as a linear process, each type of coding can happen anytime during the coding of the data.

The constant comparison method is an integral part of the coding process and involves constantly comparing an incident for a category with previous incidents in the same category, leading to the creation of categories that are coherent and distinct, with clearly defined characteristics and parameters (Glaser and Strauss 1967). Another integral part of the coding process is memo-writing. In memos, ideas are outlined, and the researcher records thoughts and insights about the ideas and any relationships that may exist between them (Charmaz 1994). These memos are written in the moment and are used later in the analysis to assist in developing the theory.

Community-based participatory research, Photovoice, and grounded theory combine to inform the dissertation study design. All three support research that is rooted in the perspectives of a population of interest. For example, two of the underpinnings of Photovoice—education for critical consciousness and feminist theory—assert that people who are marginalized have a voice and should participate in the public dialogue impacting their lives. However, it is important to note that a theory or set of theories is not being used to guide the study. Rather, a grounded theory approach will be used to advance a model of fundamental causality rooted in the experiences of the research participants. Much research in the area of racial/ethnic disparities in health has been driven by researchers and academicians, but in keeping with the principles of CBPR, this dissertation attempts to engage community members in defining the research agenda by exploring what they believe are the underlying factors or fundamental causes of poor health outcomes.

CHAPTER 3

Methods

Study Context

This dissertation study is embedded within a National Center for Minority Health and Health Disparities-funded community-based participatory research (CBPR) project entitled Accountable Communities: Healthy Together (ACHT). The ACHT partnership is aimed at understanding and redressing the health and social issues contributing to health disparities in five predominantly low-income African-American neighborhoods in Atlanta known as Neighborhood Planning Unit-V (NPU-V, V as in Victor). Some of the key aspects of the ACHT partnership are: 1) its use of community forums to deliberate with community members about the health issues that they face and decide upon intervention strategies, 2) its employment of community members as health workers to gather data, disseminate information, and plan and implement intervention strategies, and 3) its commitment to undertaking a strategy to address distal social and economic issues alongside proximal health issues. The full version of the ACHT specific aims can be found in Appendix A.

NPU-V is one of 24 Neighborhood Planning Units (NPUs) in the City of Atlanta. An NPU represents a specific geographic area within the city and each has a citizen advisory council responsible for making recommendations to the Mayor and City Council on matters of zoning, land use, and a range of other social and economic determinants

that influence health and quality of life. The five NPU-V neighborhoods are Adair Park, Mechanicsville, Peoplestown, Pittsburgh, and Summerhill. Many residents still consider Capitol Homes, a low-income housing community, as a sixth NPU-V neighborhood although it was demolished and redeveloped into a mixed-income community now called Capitol Gateway.

In 2000, the population of NPU-V was 15,825. Women comprise 54% of the population, and 92% of residents are African American. There are approximately 5,729 households, 66% of which are renter-occupied. The unemployment rate is 20% compared to 14% for the rest of the city; 59.3% of children live below the federal poverty level compared to 38.3% for the rest of the city and 22.6% for the county. Only 53% of adults have a high school diploma; the high school completion rate at the local Carver High School is only 28.7% (Neighborhoods Count 2004).

The five neighborhoods within NPU-V have distinct population characteristics. For example, Adair Park is 75% African American and has higher levels of employment and owner-occupied housing than the rest of NPU-V; whereas, Mechanicsville, Peoplestown, and Pittsburgh are 94% - 97% African American with higher levels of unemployment compared to the rest of NPU-V and the city of Atlanta (Neighborhoods Count 2004). NPU-V also struggles with its own health disparities compared to the city of Atlanta and other neighborhoods in Atlanta. NPU-V residents have disproportionately higher rates of diabetes, asthma, and deaths due to cancer compared to a similarly sized yet demographically different NPU (see Appendix B for one example of these disparities).

NPU-V also exists within the context of a city with billions of dollars in development investments (Atlanta Development Authority 2006). Similar to the experience of other neighborhoods across the country, development in NPU-V has contributed to substantial levels of displacement and gentrification. Between 2001 and 2007, approximately 1500 families (about 10% of the population) were displaced from three low-income housing communities managed by The Atlanta Housing Authority and a private developer. Two of these low-income housing communities (Capitol Homes and Pittsburgh Civic League) were demolished and redeveloped into mixed-income communities; one (McDaniel Glenn) has been demolished after 38 years in the community and is currently undergoing construction. In addition to these multi-family developments, there are a significant number of single family homes being built in NPU-V.

Collaboration

The ACHT partnership uses a community-based participatory research approach. Green, George and colleagues (2003) suggest a set of guidelines to follow in applying CBPR: multiple channels for resident input; research questions originate with the community; research addresses community priorities; activities build on prior and developing competencies of community members; residents have a major voice in methodology; residents are committed to the rationale for community intervention. These guidelines and others (Israel, Schulz et al. 2003) serve as the foundation for the ACHT partnership and this dissertation study. The ACHT partnership will not be described in detail here because the organizations that collaborated on the Photovoice

project are not members of ACHT. They are partners specific to the Photovoice component, which is the focus of this dissertation.

This dissertation study involves four collaborators: NPU-V residents, Georgia State University Institute of Public Health, the Center for Working Families, Inc. (TCWFI) and the Annie E. Casey Foundation Atlanta Civic Site. My affiliation is with the Institute of Public Health at Georgia State University (GSU IPH) as Project Director for the overall ACHT project. In that role, one of my responsibilities was to implement the Photovoice methodology as one of the project's needs assessment activities. I first approached the Community Organizer at TCWFI because he had expressed an interest in the Photovoice methodology after a presentation that I made about Photovoice before the NPU-V Board. He had previously conducted a loosely structured photography project to document the "Terrible 24" (houses that needed to be demolished in NPU-V) with some success in getting dilapidated houses torn down. As a result of my presentation on Photovoice and his previous photography documentary project, he was interested in conducting a Photovoice project as part of TCWFI's community building efforts. He believed that if people named issues in their own voice, they would begin to own the process for creating change in their community. He was also well-known in the community and appeared to be connected to many of its residents. As an outsider, I was aware that I would need a partner who was connected inside the community. We discussed the possibility of combining our efforts and involved the Vice-President of Community Building at TCWFI in further discussions.

I was then approached by the Data Coordinator at the Annie E. Casey Foundation Atlanta Civic Site (AECF/ACS) because the Foundation was also interested in supporting

residents' use of Photovoice to document the housing experiences of residents of McDaniel-Glenn. The Data Coordinator at AECF/ACS learned about Photovoice from the Community Organizer at TCWFI. TCWFI is an initiative of AECF/ACS; therefore, staff members at both organizations have close working relationships. In our efforts to avoid duplication and burdening residents with multiple Photovoice projects, all three organizations collaborated to develop the NPU-V Photovoice Project and shared the responsibility for planning, dialogue co-facilitation, recruitment, and cost sharing. GSU IPH provided the most significant planning and fiscal support. TCWFI provided greater recruitment and follow-up support, while AECF/ACS provided significant salary support as well as other fiscal support. TCWFI and GSU IPH shared the facilitation responsibilities equally. We decided to share facilitation because 1) the TCWFI Community Organizer was well-known in the community and more trusted than the GSU study PI and 2) the TCWFI Community Organizer had a keen interest in learning how to facilitate Photovoice workshops for current and future use as a community building tool.

The NPU-V Photovoice Project was designed to engage two groups of residents—residents at large and residents of McDaniel-Glenn. In order to accommodate McDaniel-Glenn residents who were in the middle of relocation, we decided to implement the study in two phases. Phase I was designed to engage the six community health workers (CHWs) hired by the ACHT project and six community residents whom they identified. Phase II was designed to engage ten residents who had been relocated from the McDaniel-Glenn Housing Community. The plan was to engage McDaniel-Glenn residents after they had settled into their new environments. We did not want to

create an additional burden during relocation, and we also anticipated greater attrition if the project was implemented during relocation.

One of the implications of this partnership and the resulting study design is the sometimes tense group dynamics created by the separation of the two phases. There appears to be some scrutiny of Phase II participants by Phase I participants because Phase II participants are less likely to be present for meetings and events. The different and lower social and economic circumstances of Phase II participants may also contribute to this conflict (see my discussion of stereotypes in Chapter 5). In addition, because Phase I includes community health workers hired by Georgia State University, some of these CHWs see Phase II of Photovoice as a project not of the partnership, but of the Annie E. Casey Foundation Atlanta Civic Site and its initiative the Center for Working Families, Inc. Therefore, Phase II is often times seen as a completely separate Photovoice project by some of the participants in Phase I. These dynamics are inherent in collaborative efforts, and we continue to struggle with these dynamics through strategic planning meetings and facilitated conversations.

Extending Photovoice Usage

In traditional Photovoice projects, participants take pictures, meet to critically analyze their photographs and develop themes, and present their photographs and stories to policymakers in a public forum. In this study, we extended the use of Photovoice in three significant ways: 1) the inclusion of grounded theory techniques, 2) the development of a public policy campaign, and 3) the integration of community organizing. In the first extension of Photovoice, the researcher used grounded theory

techniques to contribute to the development of themes. Although participants, through the theme-building exercises at the end of each workshop, identified very similar themes as identified in the grounded theory analysis (e.g., proliferation of trash, vacant and abandoned houses), the specificity of grounded theory analysis adds validity to the findings. Because of the systematic way in which data are coded, compared, and elevated to categories which are then dimensionalized and compared to define relationships, there is less room for findings to be based on the incomplete memory and recall of group members.

The second extension of Photovoice relates to the way in which we interpreted the third goal of reaching policymakers (see Appendix C for a description of the policy change campaign Dirty Truth that was developed from this process). In general, Photovoice projects have used a public forum in which participants display and discuss their photographs and stories as the primary means of reaching policymakers. In this study, participants and researchers developed a campaign with many components (e.g., one-on-one policymaker outreach, community assessments, and media advocacy) in addition to a public forum. The Dirty Truth Campaign has helped to build and sustain momentum around the Photovoice pictures and stories.

The third extension of Photovoice that also assists in building and sustaining momentum is the inclusion of community organizing and community outreach as critical components of the Photovoice process. Since the completion of the formal small group dialogues, participants have continued to present their photographs and stories to community groups and policymakers. This level of involvement may not have been possible without the relationship building skills and diligence of the project's community

organizer. In addition, the community organizer took the lead on developing the Dirty Truth Campaign's community mobilization strategy, which includes door-to-door outreach, living room chats, movie nights, and neighborhood cookouts, all activities that the Campaign has sponsored to raise awareness among community residents and to begin mobilizing them around the issue of the built environment broadly, and vacant properties and displacement specifically. In addition to funding, partnering with a community organizer and involving community health workers in outreach increased the sustainability of the Photovoice process and Campaign.

Throughout this chapter, several references will be made to the ways in which this study's methodology was modified to address unexpected circumstances. Additional strategies used to address limitations in the methodology are discussed in chapter 5 in the section on Strengths and Limitations.

Sampling and Recruitment

Phase I of NPU-V Photovoice utilized a convenience sample (Creswell 1998) of the community health workers hired by the ACHT project. Each of the six CHWs resided in one of the NPU-V neighborhoods, with the exception of Summerhill (we were unable to hire a resident from Summerhill in the first year). These six CHWs were invited to participate in the study because they represented 4 of the 5 communities and I had begun to develop trusting relationships with them through our work together on the ACHT project. In addition, the Community Organizer at TCWFI had relationships with all the CHWs prior to the Photovoice project.

The study then employed chain referral selection (Creswell 1998), whereby the initial study participants (CHWs) suggested potential study participants based on the selection criteria described below. We hypothesized that if CHWs recruited study participants, the potential for high rates of attrition would be reduced. This was important given the iterative nature of Photovoice and the long-term involvement around policy advocacy that would ideally continue to involve participants. Phase II of the study also utilized convenience sampling. The Center for Working Families invited the participation of those residents from McDaniel-Glenn who were seeking employment through the Center's many training programs.

Exclusion Criteria

Study participants could not be residents of other NPUs unless they had been involuntarily relocated within the past two years from the NPU-V community.

Phase I Recruitment

The six ACHT community health workers were invited to participate in the Photovoice process. These six CHWs were residents of four of the five neighborhoods and ranged in age from 24 to 46. There were four women and two men with varying levels of civic involvement in and outside of the neighborhood prior to their engagement in the ACHT project. These CHWs were individually responsible for recruiting six additional participants (one each) using the following criteria: 1) a resident or recently relocated resident of one of the five NPU-V neighborhoods, 2) between the ages of 18 and 25, and 3) not currently participating in the general body NPU-V meetings or any neighborhood level meetings. Criteria 2 and 3 were designed to involve younger participants and those who were not civically involved in the NPU. This recruitment

effort yielded seven additional participants for a total of 13 participants in Phase I. One CHW did not recruit any participants, and two CHWs recruited two participants each.

Phase II Recruitment

Phase II participants were recruited by the Community Organizer at TCWFI. Letters of invitation were sent to McDaniel-Glenn residents, who were also clients of the Center for Working Families, inviting them to an informational dinner about the Photovoice project. Those interested in participating were then invited to attend orientation and training. Prior to orientation, several unsuccessful attempts were made to reach those who had expressed interest in the project. The TCWFI Community Organizer then began door-to-door outreach to locate participants as well as recruit additional participants. There were ten adults at the orientation, seven of whom committed to the project. The criteria for this phase were: 1) a current or former resident of the McDaniel-Glenn Housing Community, 2) between the ages of 18 and 50, and 3) not currently participating in the general NPU-V meetings or any neighborhood level meetings. Criteria 1 and 2 were important to the Center for Working Families and the Annie E. Casey Foundation because they were interested in the experiences of working-age McDaniel Glenn residents as part of their workforce development and responsible relocation efforts. The upper age limit was included to maintain similarity in age range between the two phases. Criterion 3 was designed to involve residents who were not civically involved in the NPU.

For both phases, the involvement of those not involved civically in the NPU-V process was important because we wanted to include additional, and possibly different, perspectives in the dialogue. Those who are involved in formal NPU-V processes may

have access to information and ideas (e.g., zoning and land use) that frame their perspectives in ways that differ from others in the community.

Incentives

Phase I participants received $25 gift checks for attendance at each dialogue session (described below), including orientation. Each dialogue session was 3 hours long; we calculated this dollar amount based on an hourly rate of approximately $8.00 per hour. Participants also received an album to store their photographs.

Community health workers did not receive gift checks because they were already receiving a monthly wage of $1040 for their part-time work on the ACHT partnership. Consent forms indicated that their participation was voluntary and that their benefits would not be affected if they chose not to participate. CHWs also received photo albums.

Phase II participants received $25 gift checks for each dialogue session along with photo albums. In addition, they received monthly MARTA (Metropolitan Atlanta Rapid Transit Authority) cards because many of them no longer lived in NPU-V and needed transportation to return to the neighborhood for meetings.

Participant Demographics

Of the 13 Phase I participants, three were male and 10 were female. There were two participants under 18 years of age. The remaining participants ranged in age from 18 to 46. Eleven of the 13 participants returned demographic surveys (see Table 1 below). The average monthly household income was $1325. The average family size was 3.6, and the average number of children was 1.36. Nine of the 11 participants who returned surveys were employed and most had at least a high school diploma or GED. Of the

seven Phase II participants, one was male and six were female. Five returned surveys. These participants ranged in age from 20 to 47. The average monthly household income was less than that of Phase I participants—$866. The average family size and number of children were greater than that of Phase I participants—7.4 and 4.8 respectively. Most of Phase II participants had less than a high school diploma.

Table 1. Participant Demographics

	Phase I	Phase II
N	13	7
Number who returned surveys	11 (85%)	5 (71%)
Gender		
Male	3 (23%)	1 (14%)
Female	10 (77%)	6 (86%)
Age Range	15-46	20-47
Average monthly income	$1325	$866
Average family size	3.6	7.4
Average number of children	1.36	4.8
Education		
Less than high school	2 (15%)	4 (57%)
High school or GED	5 (39%)	0 (0%)
Some College	3 (23%)	1 (14%)
Bachelor's degree or greater	1 (8%)	0 (0%)
Missing	2 (15%)	2 (29%)
Employment		
Employed	9 (69%)	3 (43%)
Unemployed	2 (15%)	2 (29%)
Missing	2 (15%)	2 (29%)
Number of years living in NPU-V		
3-9	7 (54%)	3 (43%)
10-17	0 (0%)	0 (0%)
18 +	4 (31%)	2 (29%)
Missing	2 (15%)	2 (29%)

Some percentages reported in this table do not add up to 100% because of rounding.

Data Collection

Overview of Data Collection Process

All meetings with participants were hosted at the Dunbar Neighborhood Center, which is a centrally located community center housing several social service agencies, including TCWFI. Phase I participants first participated in an orientation/training session

in April 2006 followed by an initial photography assignment and small group dialogue, all occurring within a three-day period. They then participated in three iterations of assignments and small group dialogues (described in greater detail below). In August 2006, Phase II participants participated in an orientation session and received a photography assignment; however, none of the participants took pictures and/or returned their cameras for developing by the appointed time even though they attended the planned small group dialogue. Because there were no pictures to discuss, we used the time to discuss strategies to overcome barriers to participation. Following this session, Phase II participants completed three iterations of assignments and small group dialogues. All participants used 35 mm 27 exposure disposable cameras. With permission from the participants, all small group dialogues were tape recorded and transcribed. All dialogues involved the study PI, the TCWFI Community Organizer, and at times the Vice-president of Community Building at TCWFI. In each phase, a final small group dialogue was devoted to reviewing the photographs and narratives to explore the themes arising from the entire process. These theme-building dialogues will be described briefly below; however, the transcripts from these dialogues were not analyzed for this study. Two member checking meetings were also conducted, one for each phase. Member checking generally refers to taking ideas back to research participants for their confirmation (Charmaz 1994). The member checking meetings are also described in greater detail below.

Sources of Data

All seven tape recordings of the small group dialogues for both Phase I and Phase II were transcribed by a professional transcriber. Participants in Phase I also completed

SHOWeD questionnaires (see below and Appendix D) for each photograph discussed although this practice was modified during the project due to facilitators' concerns that some participants were struggling with literacy. Participants in Phase II did not complete SHOWeD questionnaires for the same reason. The study PI also utilized a standardized form (see Appendix E) to document dialogue session details such as pictures discussed, participants present, and challenges arising out of each dialogue session. These forms were completed after each dialogue session. The study PI also collected demographic data (see Appendix F), including age, household income, household size, and level of education. These data were reported in Table I above. Two audio files from the two member checking meetings are also included in this data set. These audio files were not transcribed.

Data Collection Process

Training took place over a three-day period for both phases. The first day involved recruited residents in a 3-hour training, which included a discussion of the Photovoice process; issues of power, ethics, and safety while taking photographs; camera basics; and a guided photo shoot. At the end of the first day, participants were asked to sign a consent form (see Appendix G) if they planned to participate. This consent form was approved by the GSU Institutional Review Board. On the second day, residents went out on their own to take photographs using the framing questions "What does health mean to you?" (Phase I participants) and "What was life like at McDaniel Glenn?" (Phase II participants) and returned cameras to TCWFI for developing. On the third day, residents met for three hours to discuss their photographs and any challenges that they experienced during picture-taking. A semi-structured, open-ended interview guide

employing the SHOWeD method, an inductive questioning technique, was used to move the discussion toward a fundamental cause perspective:

> What do you **S**ee here?
> What is really **H**appening here?
> How does this relate to **O**ur lives?
> **W**hy does this situation, concern, or strength exist?
> What can we **D**o about it (Wang 1999)?

Initially, Phase I participants captured these responses on worksheets; however, this practice was modified after the second dialogue session due to literacy concerns. Instead, participants were prompted by the facilitator to state their name, picture number, picture title and their verbal response to the SHOWeD questions so that this information could be captured on the tape recorder.

As stated above, Phase II participants returned for the first small group dialogue; however, none of the cameras were returned for developing. Thus, we spent time discussing strategies to overcome barriers to fully participating in the project. One solution involved the Community Organizer picking up the cameras from participants' homes due to the difficulty they experienced getting the cameras to the Dunbar Center on public transportation from their various locations outside of the city. The participants decided amongst themselves to drop cameras off at the nearest person's house to limit the number of stops the Community Organizer would need to make.

Phase I participants met every three weeks over a 9-week period to discuss photographs from the previous photography assignment. At the end of each dialogue session, the participants and facilitators created the next photography assignment based on the themes derived from the dialogue. The participants were then given two weeks to take pictures and return the camera to TCWFI for developing. The dialogue session took

place a week later. Phase II participants met every week to discuss photographs. Because of the many barriers to participation that these participants were experiencing, we engaged participants in a discussion about the planned 3-month time frame for the project to determine its feasibility. Together, the facilitators and participants agreed to three dialogue sessions spaced one week apart, which would require more logistical pressure for the study PI and co-facilitators but was more feasible for study participants.

At the opening of each dialogue session, the study PI asked participants to review their developed photographs and choose two for sharing with the group. Each participant was prompted by either the study PI or the Community Organizer to describe his/her photograph using the SHOWeD format followed by an open discussion with the larger group. The facilitators used probes like "do others have a similar photograph or experience?" or "does anyone have a different perspective on this photograph or story?" to generate group discussion. At the end of both rounds of sharing, the study PI asked each participant to write on note cards their perceptions of the two strongest themes from the discussion. These note cards were transcribed onto a flip chart followed by a facilitated group discussion of themes. Because of his background in mediation, the Vice-President of Community Building at TCWFI facilitated some of these discussions. The study PI facilitated the others. Participants decided the strongest themes by combining similar concepts and eliminating others that did not seem relevant. This discussion of themes was not used as part of this study's data set. Participants also suggested framing questions to guide the next iteration of picture-taking. These framing questions are not a part of this study's data set.

Data Analysis

To code data into common themes, transcripts of the seven dialogue sessions were first loaded into NVivo 2.0. NVivo 2.0 facilitates coding by allowing the researcher to highlight, save, and store codes electronically; view all sentences with the same code; view all codes in the document simultaneously; create trees that outline the relationships between codes, as well as other functions. Two separate NVivo projects were created for Phase I and Phase II to allow for possible distinctions between the two groups to emerge. Line-by-line coding was initially used to label phenomena. Line-by-line coding is a strategy which prompts close study of the data—line-by-line—and assists the researcher in conceptualizing ideas (Charmaz 1994). It means that each line of the written data is named or provided with a label (Glaser and Strauss 1967). The constant comparison method (Glaser and Strauss 1967) was then used to compare codes to create categories. For example, participants expressed several times in the transcripts that various people do not care about them or their community (e.g., White people don't care, people with power don't care). Using the constant comparison method, I labeled all incidents with a similar code under the category of "not caring." I then asked questions such as "Who doesn't care?" "How do we know that they don't care?" "Why don't they care?" "What happens when they don't care?" and "What does caring look like?" to understand the properties and dimensions of "not caring." Answers to these questions identified through further analysis of the data defined two types of "not caring." I identified the first type of "not caring" as akin to apathy, involving feelings of hopelessness and defeat. I identified the second type as more akin to indifference, which has more in common with feelings of disdain. After conducting a similar process for all the major categories and their

subcategories, relationships between the categories and subcategories were analyzed using selective coding to begin developing a grounded theory.

Member Checking

Two member checking meetings were conducted, one each for Phase I and Phase II participants. Member checking generally refers to taking ideas back to research participants for their confirmation (Charmaz 1994). In each member checking meeting, I described the major categories/themes that I had identified during coding and provided participants with supporting quotes. The participants were asked to assess whether the findings mirrored their own analysis of their pictures and narratives. Participants were also provided with a diagram relating the categories to each other. They were asked to assess whether the relationships made sense and to note any missing concepts. They were also asked to create labels that best expressed some of the categories, which were then included in the model in chapter 5. Both 2-hour meetings were recorded.

CHAPTER 4

Study Results

To answer the study's overarching research question and the five related research questions, grounded theory analysis was conducted using data collected from seven dialogue sessions. Two member checking audio files were also used to verify the study findings. Direct quotes from participants are followed by a bracketed number that serves as a participant identifier. References to specific photographs are also included (See Appendix H). Study findings are summarized in a table at the end of this chapter. In the subsequent chapter, an explanatory model based on these findings will be presented.

Research Question 1: What do Residents of NPU-V Perceive to be their Priority Health Concerns?

Unlike the conventional public health framing of health in terms of physical health outcomes, throughout the Photovoice process residents rarely discussed physical health as a priority health concern. When they did so, they placed physical health in the context of environmental conditions that they believed contributed to poor health outcomes. For example, according to one participant, the "Black diseases" of high blood pressure and diabetes are the result of the availability of fried foods.

> *Grady Hospital, the biggest hospital in the world, serves the most, you know, the most people who are poor. There's a damn McDonald's built into it. Of all the restaurants that you can build, McDonald's is built into Grady Memorial Hospital. So I was really down there, I was really just cruising one day and I said*

> *what is it that I want to say on a picture? So it came to me. We just have all fried food around us. Subsequently, we've got high blood pressure, we've got diabetes, we've got a whole lot of things. [005]*

Another participant also pointed to fast food chains as the reason for disease as she examined her photograph, which she entitled "Fast Food Nation" with several fast food chains in the background and an ambulance in the foreground (see Appendix H).

> *And the irony…is that there is an ambulance placed there, which speaks to the fact that these chains feed us, and they also hospitalize us…They are the reason why we have the heart disease and the health problems that we have as a society, more so as a community. [012]*

This participant described the relationship between physical health and the availability of healthy foods as she examined her photograph "Danger" of a local corner store (see Appendix H).

> *I do not see a healthy store... They don't have groceries like vegetables…this particular store is killing all the neighbors in our neighborhood because they sell alcoholism…there's nothing there that is healthy for our bodies. [001]*

The quotes above describe the few instances in which participants mentioned physical health and the diseases such as diabetes and heart disease that are typically used to characterize racial/ethnic health disparities. Although important, in comparison to the many other issues that were raised by participants, the relationship between the availability of healthy foods and physical health was minimally discussed by participants. Therefore, little of this dissertation study is devoted to analyzing this commonly discussed relationship in the public health literature. To note, the local corner store described above is, however, indicative of the disinvestment described by residents that will be discussed in the context of research question three.

During axial coding of the Phase I transcripts, as I related the categories and subcategories to each other, many of the categories (e.g., displacement, neighborhood

disinvestment, and indifference, which will be described within the context of research questions two and three) were described by participants as causal conditions of poor community well-being. Therefore, **poor community well-being** emerged as the major outcome of interest for Phase I participants. Likewise, many of the categories in the Phase II transcripts (e.g., displacement, housing disinvestment, and indifference, which will also be described within the context of research questions two and three) were described by participants as causal conditions of poor mental health. Therefore, **poor mental health** emerged as the major outcome of interest for Phase II participants.

The major characteristics of poor community well-being identified are 1) fewer community places, 2) lower levels of concern for each other, 3) reduced levels of connectedness and relationships, and 4) fewer indigenous caretakers. Even though these are not physical health outcomes, I understand these outcomes to be priority health concerns for Phase I participants, hence as the health-related outcome of interest. The major characteristics of poor mental health identified by Phase II participants were 1) stress and hopelessness, 2) alcohol use, and 3) suicide ideation. Below, I discuss each of the characteristics of poor community well-being and mental health.

Poor Community Well-Being

Fewer Community Places

Place-based identity was a major theme in the Photovoice dialogue sessions. Not only did people talk about being bound to each other, but they also talked about being bound to the physical place. According to participants, community places have meaning, are sources of identity, and are required to keep people together so that they can sustain relationships and a sense of connectedness. For example, as she analyzed her picture

entitled “Atlantis in Atlanta” (see Appendix H) of a demolished low-income housing community in response to the first SHOWeD question “what do you see here?”, a participant described the meaning that she attributed to the place.

> *What do you see here? A place that has sheltered, nurtured, buried, birthed a people for at least 20 years. [005]*

Another participant merged his own identity with that of one of the five neighborhoods of NPU-V when he stated “I still stay over here, and I’m still a resident over here. And I’m Pittsburgh” [008]. This participant made this statement in the midst of a conversation about outsiders’ view of him and his neighborhood. This statement was his way of asserting that he identified with the place even though the place, in his view, was not valued by outsiders.

Another participant talked about a place—the projects—as having a purpose. It provided people with an affordable place to live and it sustained connectedness.

> *I remember when the project was a good thing. When the projects first came about a lot of Blacks didn’t have no where to stay. So when they built the projects, they was glad to get into the projects because they had somewhere for their family to live that they could afford. They didn’t have to worry about that. And it lasted, it kept them together. [001]*

Even though the living conditions in the McDaniel Glenn housing community were substandard (see themes arising out of research question three), one positive aspect of public housing, beyond affordability, was that it allowed people to sustain relationships vital to maintaining community well-being.

The discussion about the meaning of place included many references to childhood memories. In the narrative below, the speaker ascribed meaning to the land through here attachment of childhood memories to the physical place. She suggested that once the people and the memories are gone, then the land loses its meaning.

I feel like it was very powerful that you used bunker to describe that land. I mean it just has so many, you feel it. You really do. And it really made it hit home for me. And I feel like it's the old regime versus the new regime. And I'm relating it to war terms. I feel like what we're seeing is a transition or a phasing out of what we know as childhood memories and of nostalgia and all of that is just being eliminated, wiped out, just like a bomb would wipe out a town… And now … the land is just the land and more people can move in on top of it that don't represent childhood and don't look, aren't nostalgic anymore. [012]

I interpret this quote in the context of the other quotes to mean that the land is not simply there to provide shelter. The physical land and its structures have meaning because people have created lives and shared events, traditions, and day to day life in that place. When that place is torn down and replaced by other structures and new people move in, then an essential aspect of residents' identity is taken away.

Reduced Levels of Connectedness and Relationships

In addition to compromising identity, the removal of public housing also fractures relationships between the people who used to live there. Initiatives across the country have been developed to deconcentrate poverty by relocating families out of public housing to other parts of the city. As a result of these initiatives, thousands of families have been displaced. In NPU-V, approximately 1500 families have been displaced. While some may define the families living in public housing by their socioeconomic status and may even be motivated by good will to improve the living conditions of poor families, there are unrecognized consequences of displacement. What these initiatives fail to account for is the fracturing of social ties that occurs with displacement and that many remaining residents of NPU-V see McDaniel Glenn residents as part of their kin network. This participant describes her view of McDaniel Glenn residents.

Well, in the example of the McDaniel Glenn Homes that were torn down, basically they're our neighbors, our friends, our family, and they're no longer there. [012]

Another participant further explained that the displacement of families not only removed the people but also the traditions that have developed over time as he described his picture entitled "New Development." (see Appendix H)

> *What is happening is what you don't see from the picture…the displacement of families and the relocation and families being moved away. You don't see that at all… How does it affect our lives? Breaking social ties and tradition that have been in the community for a while. [009]*

Participants discussed at length the levels of connectedness to each other that they once felt. They described those relationships that used to exist between people that allowed them to take care of the community places and each other. This participant described the relationships that her parents had with other neighbors while she lived at Grady Homes. These relationships enabled them to advocate for a community place—the neighborhood park.

> *The part that's right there in front of Grady Homes, the part that my mother and father and their friends advocated, I'm talking about my childhood, the apartments that my mother and my father and their friends advocated for us to have a park there. We had a swimming pool, we had swings, we had sliding boards. And now when I go back and look where we played, it reminds me of a bunker in Germany. And not that I've been to Germany, but I do a lot of reading. [005]*

The fracturing of relationships is not inconsequential. Residents express tremendous loss when they talk about dwindling relationships, traditions, and resources that these relationships have been able to garner for those in the network. They recognize that a community cannot be well if its relationships are broken. For example, the ability to advocate on behalf of one's community for parks or other amenities requires people and relationships. Without these relationships, there is a sense that people are less connected and care less about each other.

Lower Levels of Concern for Each Other

Possibly as a result of the fractured social relationships, participants described the sense that residents are now less concerned about each other than in the past. This participant referred to this lower level of concern as he analyzed his picture "Love for Humanity" of a man in the neighborhood who is homeless and familiar to many (see Appendix H).

> *I want to know what happened to all the love in the Black community man. What happened to concern for people that are going through things like this?... This man is us, I just want to say that. We are this man. So goes this man, so goes us. And I'm going to leave it like that. [009]*

Another participant also described this lower level of concern in her discussion of a teacher-parent-student relationship.

> *Like I can remember one teacher who would come and knock on my door. If I missed a day of school my teacher came and knocked on my door and was like well, I noticed that your child wasn't in school today. My mom was like oh, she was sick or whatever and I'm glad you were concerned. [003]*

Because care and concern happen in the context of relationships, it is reasonable to expect that when networks are disrupted and relationships are compromised, then the sense that others care is diminished. The lack of concern that these narratives point to is described in relationship to time—this concern used to exist in the past but is less likely to exist now. This concern for others is important to community well-being because socially supportive relationships may help to mediate problems like the decline in physical and mental health as a result of homelessness (in the case of the homeless man) and high school drop-out (in the case of the teacher and student). The loss of place-based identity, relationships, and the sense that people in the community care about each other

all combine to characterize poor community well-being. To reiterate, health in the voice of the residents is more broadly defined to include this loss of community well-being.

Fewer Indigenous Caretakers

While "fewer indigenous caretakers" did not emerge as a strong theme[1], this participant's reference to the public housing complex in which she was raised was provocative. She described the loss of a community wherein people who served the community lived in the community.

> *I remember we used to play over there [crying]...the principal stayed right around the corner from me… My first grade teacher stayed right down the street from us. It was a mixed community, and they talk about mixed communities now. [005]*

She continued.

> *The people that used to build for us in Parks and Recreation were people that stayed in Grady Homes, stayed in some of the houses that are over there near the high school, near Howard High School. It was truly a mixed area. [005]*

Her use of sarcasm to criticize the current definitions of "mixed" is noticeable. The type of "mixed" for which she advocates is the residency in the community of indigenous caretakers such as teachers, principals, and city workers; whereas, the "talk" about mixed communities now is mostly income-based (Atlanta Housing Authority 2007) and has become a fixture in community discourse because of the large mixed-income developments that are being erected in and around the neighborhood. Her narrative suggests that there are broader ways of sustaining community well-being that include residency in the community of people who serve the community.

---

[1] Because this participant was one of the older participants, the way in which she described community may not have resonated with the younger participants, for whom the idea of indigenous caretakers may not be relevant because the phenomenon no longer exists.

Member Checking Results

One of my assumptions going into this research was that participants would not describe health in traditional medical terms although I was not sure how they would describe it. I based my assumptions on elements of African-American culture, such as an orientation toward family and community-level social networks (Stack 1974; Hill 1993) that could suggest more focus on community well-being and less focus on individual health concerns. Although it appears that the findings support this assumption, I asked the group during the member checking meeting about their reasons for talking less about traditional health outcomes and more about community outcomes. They didn't respond in a way that supported my hypothesis that community well-being was synonymous with health; rather, they suggested that health was secondary to more immediate concerns such as survival. One participant responded to my question by stating:

> *If you live somewhere for more than five years, you have a sense of community and belonging and then all of a sudden you are told that your house is foreclosing or that you have to move out of your apartment by a set due date, that's a total shift change. And then you have to figure out how am I going to navigate through the city or get to work or from work, or trying to find new means of supporting myself and my family… so I think if mentally your mindset is always on how am I going to feed my family or how am I going to support myself…this shapes how you are going to look at your health. We as Black people generally look at it as I need to survive first and then I'll get to my health. [008]*

In response to the research question "What do residents of NPU-V perceive to be their priority health concerns?" it appears from Phase I participants that these concerns primarily involve **poor community well-being**. Concerns about the community's well-being impact one's ability to attend to health issues, which were rarely named explicitly but include heart disease, high blood pressure, and diabetes. These community concerns supersede health concerns because they are more pressing. It is also possible that

because of the importance of community in African and African-American cultures, individual well-being (the more standard way of framing health) is secondary to community well-being.

Poor Mental Health

Stress and Hopelessness

Unlike Phase I participants, Phase II participants were not asked to use their cameras to specifically document health concerns. They were asked to use their cameras to tell us about life more generally at McDaniel Glenn. The photographs and stories in this group yielded painful discussions about feelings of stress and hopelessness, which are connected to the themes of housing disinvestment, displacement, and Atlanta Housing Authority (AHA) indifference to be discussed in the context of research questions two and three.

One participant used metaphors each time she tried to explain her and others' feelings of stress and hopelessness. She compared these feelings to being in a dark room, light bulbs being unscrewed, and trying to open locked doors.

> *We've already got enough things within ourselves. We try and comply every way you [Atlanta Housing Authority] ask us. It's not like we're not trying to do what you ask us. But when you keep on making it harder for us and we've already got a lot of issues and a lot of stuff bottled up in us, where do you want us to go? I mean you're putting us in a dark room with no light. [016]*

In another dialogue session she said:

> *It's like this. Okay, we are here, right. And you screw the light bulb into the, I mean the bulb into the light post or whatever you have. And then once you disconnect it and you're just full of darkness, you feel like you're hopeless. [016]*

The stressors that were most often expressed by participants were related to housing conditions and displacement; however, there were other stressors in the social

environment contributing to poor mental health. In one dialogue session, the facilitator asked if others had similar feelings of hopelessness after the above narrative was shared. One participant talked about his feelings of giving up after his brother was killed in a police car chase.

> *They done got my little brother really, you know what I'm saying? He was in a car and the police chasing him, and they ain't supposed to be chasing him like that. And they made him really kill himself, you know what I'm saying. I was at that point. But I ain't talking to nobody. I ain't going to no counselor. My friends, they told me, they told me, "Don't do it like that. There was a reason for that." That right there, that's real personal. [017]*
>
> *Tell me a little bit about your friends, like the incident happened, and it sounded like you were saying that you were angry. And what did your friends tell you? [Facilitator]*
>
> *They were like keep your head up. He's gone to a better place. We know you're pissed off right now, but don't go try to hurt yourself or hurt nobody in the process. They'll talk to the man upstairs...everything would be alright. But at that time I was listening, but it was going in one ear and out the other. [017]*
>
> *During that period of time you felt like giving up? [Facilitator]*
>
> *I had done gave up. I was like…everybody and everything. I don't even care no more. With my baby brother gone, he didn't even make it to see 16. I'm 19. That hurts so bad, so, so bad. Let's talk about something else. [017]*

Even though the above participant talked about mental health in terms of his brother's death, which is not directly related to the issues of housing disinvestment, displacement, and AHA indifference, I include it here to demonstrate that in addition to these issues, participants are also dealing with other stressors in the social environment such as crime and policing, which will not be included in the explanatory model because they are not central to the main storyline (i.e., the way in which the built environment and development decisions impact a community's health and well-being), although they are important and related aspects of life in this community.

Alcohol Use

As a result of her depression following her nephew's murder, this participant describes her use of alcohol. Again, I include this narrative here to contextualize participants' stressors related to housing disinvestment, displacement and AHA indifference in the context of other stressors.

> *I stayed in the dark for 12 years. I mean I stayed in the house for about two months. And then after that I was on a drinking spree, up and down spiral. Still cared for my family and my kids. But it took 12 years until I walked in a church door and this young lady… and she said that's what God said you were here for, for me to talk to you. You've been going through something for a long time, haven't you? And I said, "Yes ma'am I have. Yes ma'am I have." [016]*

Although this was the only reference to alcohol use in the transcripts, there were two dialogue sessions in which two different participants (one in each session) were inebriated. I was interested in understanding alcohol use in the context of feelings of stress and hopelessness. During the member checking meeting, I shared a diagram of relationships with participants that included alcohol use and asked if it belonged there.

Member Checking Results

One of the participants made this comment related to alcohol use as a result of stress. I have removed the participant identifier to avoid any possibility that this participant's narrative could be connected to her identity.

> *I know I be drinking like I don't know what. [Whispering] I done drunk when I was pregnant and all of that.*

I asked, do you think that was related to stress?

> *Yes. I felt down. I was just like I gotta get up and go or else I will go crazy. I had to have a drink.*

This participants' whispering about alcohol use during pregnancy was a clear indication that she understood the consequences, social or otherwise, of drinking during

pregnancy. However, she expressed feeling "down" and "crazy" which may be indicative of symptoms of mood disorders like depression and anxiety. Because of these feelings, she used alcohol to cope.

Suicide Ideation

The following narrative describes the stress of trying to fulfill AHA work requirements while not being able to secure childcare and the associated threats of housing loss and intervention by the Department of Family and Child Services (DFACS) if children are left alone. These stressors are being discussed in the context of suicide ideation.

> *Mine [my story] is personal, but I was in the, you know how you be in the state of mind where you want to commit suicide and all that. The people upstairs [in the Dunbar Center], what's their name? Resource moms…she helped me out a lot. I'm talking about a lot. I mean she saw me crying every day about me and my kids, you know it is being single parent and everybody's father be in jail and I'm talking about I was struggling. [015]*

She continued:

> *And then Housing (AHA) is on my, they on me like white on rice. They said they don't provide childcare. And I would say okay, well, how would I work? And then if I go back to working at night, which I always have night jobs, they [DFACS] told me my 13-year-old, he can only watch him [the baby] for like an hour. I said well, how am I going to do it? [015]*

These two narratives again express multiple stressors. However, I focus here on the simultaneous pressures exerted by AHA and DFACS, agencies that are mentioned repeatedly in the transcripts. Without affordable childcare, this participant is faced with the threat of housing loss if she does not work or the threat of losing her children if she works and leaves the children home alone. The sense that they are being pulled in multiple directions is common for Phase II participants. Suicide then becomes an option to escape from a situation that seems hopeless.

Member Checking Results

When I read the narrative related to stress and suicide ideation in the member checking meeting, I asked if others had similar feelings; all participants nodded in affirmation. One participant related her own story about the stress related to the threat of DFACS.

> *Sometimes you have to do what you have to do. And I explained that to the DFACS worker. If you were in my shoes, you would see where I am coming from. The reason why I like the night jobs is because I feel like my older child can [watch the others]… where I don't have to come out of pocket. For the baby, it's like $100 plus per week, and there aren't jobs out there paying like that. Clothes and shoes, it's 7 of us, and you have to buy pampers and milk, and I feel like, there ain't no jobs… and I didn't finish school. The jobs that I applied for, you have to have a driver's license. I don't have that. It's hard. I want to work overnight so that I don't have to pay for childcare and then I feel like they are safe if they are with each other. [015]*

In the dialogue session, the above participant provided us with a view of major stressors like lack of childcare, the threat of housing loss, and the threat of losing her children in the context of the stressor of single parenthood. In this narrative, she continues to share other stressors, such as the lack of education, the lack of good paying jobs to support her family's needs, and the lack of identification. All of these combine to impact her psychological well-being.

In response to the research question "What do residents of NPU-V perceive to be their priority health concerns?" it appears from Phase II participants that these concerns primarily involve **poor mental health**. The multiple psychosocial stressors experienced by residents in this group contribute to feelings of stress and hopelessness as well as alcohol use as a coping strategy. In severe cases, some residents considered suicide. In summary, the priority health concerns for Phase I and Phase II participants are poor community well-being and poor mental health.

Research Question 2:
What do Residents Identify as Factors that Contribute to Poor Health Outcomes?

The most oft-repeated sentiment in the Phase I transcripts is that someone or some group "doesn't care." This phrase is discussed in two ways by participants. I describe the first as apathy, which is a feeling that participants believe is mostly experienced by people who live inside the neighborhood. This concept will be discussed in greater detail within the context of research question four as an inhibitor of improved health outcomes. I describe the second type of "not caring" as indifference, which is a feeling that participants believe is mostly experienced by people who live outside of the neighborhood. Indifference is, many times, discussed by the participants in the context of negative perceptions about the community and the people who live there.

In this section, I explore **indifference** as a factor contributing to poor community well-being and poor mental health. Participants believe that people outside of the community feel disdainful toward them and express feelings of "not caring" as a result. Although "not caring" can be defined as apathy or indifference (they are synonymous), indifference is also synonymous with disdain (apathy is not), thus the reason for labeling outsiders' "not caring" feelings as indifference and insiders' "not caring" feelings as apathy.

One of the more harsh statements about what people outside of the community may believe about low-income Black people came from this participant.

> *I try not to have people over to my crib…, it hurt coming up that you want people to visit you, you want people to see where you're at. You want to take pride in your own community, but it's hard when every time people do come around you the perception is, they look at it as the only people that live here are trashy, low income, like reprehensible kind of Black people that nobody needs to really deal with or give a damn about. [008]*

In addition, participants talked about the indifference that the developers (a type of outsider) must feel given that they leave trash in the neighborhood.

> *A lot of the people that are coming in and building these new houses really do that, just when they're through with whatever they're doing for the day and there's an abandoned house they'll just take their scraps and just throw it right there because of the simple fact it's abandoned and it looks bad, so they don't care. [002]*

There are also some outsiders who express indifference toward the community because they think that members of the community don't care or that no one is there with power to resist or enforce regulations.

> *And what is harsh, why I don't like it [saying that this community tolerates] is because I know other people, that's their justification. Well, they tolerate it. They'll settle for it, so we'll just dump it in their community or we'll just leave these houses abandoned and not boarded up or we'll let people come in and steal the stuff because they'll settle. They won't complain. They don't care. And I don't want that for us ultimately. I don't want that to be the outcome of our community, and I don't want people to view our community in that way. [012]*

The above examples depict participants' perceptions of outsiders' perceptions of the community that drive their indifference. Developers represent one type of outsider that was named specifically by participants. One way in which abandonment creates additional blight is through the trashing of the neighborhood by developers, who may believe that no one is there to care about the community. Participants also believe that others view them poorly based on their race and social class, and as a result, act in ways that are detrimental to community well-being.

The narrative below refers to Black people who were once insiders to the community who are now outsiders and don't care about the community. In reference to his picture "The Pool" of a community place—the Dunbar Pool (see Appendix H)—that

is not available for use by the children in the summers, this participant responded to the SHOWeD questions, “why does this exist?” and “what can we do about it?”

> *They don’t care about the Black community. [We can] talk to the mayor or talk to Shirley Franklin, talk to the city council people, talk to somebody in the City of Atlanta because that’s who is responsible for that pool. [004]*

I then asked, “Who is they?” He responded by saying.

> *The people, I’m not even going to stereotype it and say the White people because there’s some of us that don’t care. Some of us that lived, grew up in these communities, got these good jobs, moved out of the community, and they don’t care about what’s going on in the same community that they grew up in, the same park that they ran around in as little children. They don’t care about it now. So, I’m not going to just say the White people. I’m going to say when I say they, I’m using us too with that. [004]*

An interesting aspect of this narrative is that this participant began to say something in reference to White people not caring and then he retracted his statement and modified it to include Black middle class people who have moved away in his analysis. After stating that “they” don’t care about the black community, he named the mayor, city council, and the City of Atlanta as responsible for the pool. The majority of the city government representatives, including the mayor and most of its city council members, are African Americans. Therefore, his initial reference to Whites may have created some cognitive dissonance for him when he realized that the people referenced in his previous statement were middle class African Americans.

Although this participant is holding middle class Blacks accountable for distancing themselves from the community, there are policies in place that supported the out-migration of middle class families from urban centers. For example, the disinvestment of city services from the city’s center and the investment in suburbs helped to create neighborhood conditions in the suburbs that middle class Black families elected

over the poor conditions in the city. Even so, participants believe that the physical and social distance between middle class Blacks and poor Blacks fosters stereotypes of low-income Blacks that lead to indifference.

Similarly, Phase II participants identified **indifference** as the factor that contributes to poor mental health outcomes, although the indifference that they observe is promulgated by the Atlanta Housing Authority and is fueled by negative perceptions of them based on social class. Participants attribute work requirements without consideration for factors such as childcare, literacy, and education to indifference or "not caring."

> *I told him [the AHA representative] I need childcare. That's what he can help me with. Don't tell me what I need to do when we were out every morning looking for a job. He was like you need to do this and do that. I need help with childcare, that's my only problem. [He said], "Well, I advise you not to have another baby." You can't tell me that. [015]*

Participants also believe that the continuous creation of new rules by AHA is part of this indifference. One participant describes this creation of new rules:

> *You're doing all the things they ask you to prior to you getting your lease…I'm gonna pay my rent, I'm gonna keep my house clean, make sure my porch is clean, and my backyard is clean. Now, after that, you come up with something else. You can't do this. You can't do this… It's like a part 1 and a part 2. It just goes on and on. [016]*

She continued by suggesting that the rules are a mechanism of control that allow AHA to retaliate and threaten residents with housing loss.

> *They want you to break a rule in order for you to be written up, and the next time we write you up, we're going to throw you out. [016]*

In general, participants thought that the rules that AHA created were constant sources of stress, particularly because the rules were connected to the threat of housing loss. Participants felt that these rules demonstrated a lack of concern about the realities

of people's lives or the ways in which people constructed their social lives. For example, rules that didn't allow people to congregate prevented residents from socializing.

> *We're not going to do what they say to do because we don't think it's fair. And what I mean by that, for example, it was last year sometime they had a rule saying that we couldn't barbecue. Y'all remember that? We couldn't have our barbecue grill on our front porch. We had to be in the house at a certain time. A certain amount of company could be there at a certain time. Come on man, we're from the hood, man. How you gonna tell us that? [017]*

Although one participant acknowledged the potential safety concerns related to barbecuing on the porch, she questioned where they could barbecue.

> *They said something about fire. We understand that… but every family that wants to barbecue today, where are you going to go? To a gazebo? Where is the gazebo at? Out in the street? [016]*

It appears from the above narrative that participants understood the logic behind some of the rules, but when rules were created without the provision of other options or without input from residents, participants interpreted these actions as indicative of indifference.

Challenges related to post-relocation housing were also attributed to indifference. One participant provides this example of "not caring."

> *This is why I really know that they [AHA] really really really don't give a damn. If you are going to give me a voucher and say go and find a house on Section 8. First of all you already know all the homes that have been approved for Section 8. Anybody with sense… why wouldn't you design a team specifically to see if these owners of the homes have been paying their mortgages or paying off their loans? How would you not know that a home is up for foreclosure and you are paying them to allow someone to live on the property? I don't understand that. [018]*

The issue of post-relocation housing is very near to this group because the issue of foreclosure affected a participant during the Photovoice project. One of the participants experienced two foreclosures because her landlord did not pay his mortgage even though he had been receiving payments from AHA. The participant who experienced the two

foreclosures provided this example as evidence that AHA does not care about their clients:

> *I think they don't care because when I was pregnant… they knew the house didn't pass inspection… and for her to say that me and my kids have to stay in a shelter, there's nothing that they can do. She can't care. [015]*

Member Checking Results

In the member checking meeting, I asked participants to analyze whether negative perceptions about the Black community exist and lead to indifference. The group agreed that these perceptions did exist. This participant discussed what she believed to be the typical perceptions of people in their neighborhood.

> *If you say "I live close to downtown" then they [people in general] got good, raving things to say. If you say Pittsburgh, they be like high crime rate, baby mama drama… If you say close to downtown, they say "you live in the historic neighborhoods." If you say your neighborhood, then they don't want to fool with you, we just dumb and fat and accept and do anything, we live in the worst neighborhood that there is. [011]*

The member checking findings confirmed participants' belief that stereotypes about low-income African Americans are at the root of indifference. In participants' survey of race and class dynamics, the negative views of poor African Americans contribute to disinvestment because of the belief, for example, that low-income Blacks will accept anything. These negative views can also lead to policies that support displacement. For example, if there is a prevailing view that low-income Blacks are viewed as possessing few middle class values (e.g., hard work, temperance, self-discipline), this in many ways justifies policies that displace poor Black families to middle class neighborhoods in hopes that they acquire these values.

In the Phase II member checking meeting, participants continued their discussion of indifference as it related to the Atlanta Housing Authority. While some people

criticized AHA for demolishing properties, this participant didn't believe that demolition, per se, was negative. Rather, she believed that AHA's attitude of indifference made the demolition and relocation process difficult.

> *I think the plan that they have could be a good plan only if they cared. If you cared, you would make sure that everything is going right. I don't feel like it's nothing wrong with bringing down a community, rebuilding it to make it better for us, allowing us to come back without all of the extra stipulations. I think it's an excellent plan to tear down anything that's raggedy and rebuild it, but if you don't have it at heart, it's not gonna work out anyway. [018]*

Another participant supported with this comment:

> *Them folks [AHA] don't care nothing about us, man. They just care about themselves, man. Trying to get theirs. They don't care where we gotta go at or where your children go at or none of that man. All that…talk about trying to help us, man. They can keep it. Keep that to themselves. [017]*

This participant relayed to the group her thoughts on why AHA acted so indifferently toward them.

> *They act like we are some kind of animals. They don't want to live around us. They don't want to be around us... I feel like that's what they are saying to us. We aren't worthy to step inside of their world. We ain't got the money and we ain't got the same skin color they got. [016]*

However, I challenged this comment because there was agreement that the people managing AHA were Black but the above comment suggested that the treatment they received was related to the fact that their skin color was different. One participant responded.

> *The lady that runs it is Black. She calls all the shots, and she's Black, but she also works for somebody. It runs skin deep… [018]*

This comment suggests that even though the face of AHA is Black, there are non-Black others who influence the actions taken by AHA. This non-Black other could be conceptualized as the ideologies about poor Blacks that have been institutionalized in

American systems, even those systems managed by Black Americans. The answers to the next research question will describe the mechanisms through which indifference translates into poor community well-being.

Research Question 3:
Through what Mechanisms do Residents Perceive that these Factors Operate?

Residents perceive that the indifference felt by outsiders (i.e., developers, White people, Atlanta city government employees, AHA employees) contributes to poor community well-being through four key mechanisms. The first is long term **disinvestment** (both neighborhood and housing), and the second is widespread **speculation.** Both lead to the third mechanism—**poor neighborhood and housing conditions** characterized by the presence of sewage, rats and roaches, trash, vacant properties, disrepair, and vandalism. The fourth is large scale, highly disruptive **displacement** of people to places that are far from the neighborhood.

Disinvestment

Neighborhood Disinvestment

Disinvestment comes in several forms from emotional disinvestment by property owners to institutional disinvestment by the City of Atlanta and other institutions. Disinvestment in these neighborhoods is also described as chronic and discriminatory in that other parts of the city receive better and more consistent city services and investments. During one of the dialogue sessions, a participant made the statement "the numbers don't work for us" in reference to her efforts to have an abandoned dumpster removed from the street near her home (see Appendix H for her photograph "I Can't See"). I had a difficult time understanding the meaning of this statement and asked

several times for clarification. I kept thinking that "not working" equated to "disconnection" or some other problem with the phone line. The following extended narrative was one participant's attempt to clarify and discuss the lack of city response to illegal dumping.

> *The numbers don't work in this way. I called last week because there was some illegal dumping going on. I called 1-800-Don't Dump. Hello. I'm standing here looking at somebody right now doing some illegal dumping directly across the street from my house. I'm taking pictures. Who can you send? The lady said, "call this number." So I hung up and I called that number. Hello. I'm standing right here looking at somebody doing some illegal dumping as we speak, how can I get some help with this? Call this number. Hello, City of Atlanta Summit Waste. I'm looking at a person right now and they're doing some illegal dumping directly across the street from my house. What do you guys do? The man said call 404-330-6000. That's the general number for the City of Atlanta. And I told him just like this, sir, I guess you think you're playing with a GD baby, but I am not the one. I hung up the phone. I called the Mayor's Office of Constituent Affairs. I said, "What is going on that you guys will send somebody to our NPU meetings, to our neighborhood meetings, give us these numbers and say call this number if you've got a pothole? Call this number if you've got, your sewer is backing up. Call this number if somebody is doing illegal dumping. Yet when I call those numbers, they're passing the buck. The lady said, what did you say? So the numbers don't work. [005]*

Another participant expressed a similar sentiment; however, he did so in the context of inequitable distribution of services to other parts of the City.

> *But their [the City of Atlanta's] main focus is Buckhead, Virginia Highlands. They all up in that area, but they don't never come down here to us. [004]*

Another participant expressed that disinvestment is deliberate in order to devalue the land so that it can be purchased at a low price by investors.

> *I think the building is deliberately ran down like that because that building sits in the wake of the Mechanicsville redevelopment plan…So it's all part, I feel like our neighborhoods are deliberately devalued so that whoever wants to come in can come in and say oh, we've just had enough. Here, take it for a dollar. [005]*

Another participant related the lack of investment over the years to the fact that low-income housing communities were in the neighborhood.

Because now that the projects are gone, the new development has come in. But while the projects were still here, there was no development being done. [002]

This statement illustrated the frustration that some residents have felt as a result of the chronic disinvestment.

We've struggled for years to say listen, all we want is just to rehab the house. All we want is just to build a new house. All we want is the trash to be picked up…We've talked a lot over the years about we're so desperate in our neighborhoods for development because we've just looked at the same thing so long… [005]

These references to disinvestment paint a picture of a neighborhood that is overrun by trash. The trash is chronic and pervasive as described by this participant as she discussed her photograph "Walk of Shame." (see Appendix H)

This wasn't the first corner of trash that I saw. I saw lots and it was everywhere, just in like the community was just trash. [013]

Residents expressed high levels of frustration from years of calling upon the city of Atlanta with little to no success. Residents recognized that their neighborhoods do not look like the neighborhoods in White affluent areas, even those within the city limits. In general, they assert that the severe levels of trash result not from insiders' behavior, although that is part of the equation, but from outsiders who dump in the community. Although there are laws that allow the city to intervene on behalf of the public's health, participants believe that the city has chosen not to invest services in NPU-V. Residents also recognize that another type of investment has been lacking, that of investment in infrastructure such as buildings, roads, and sewer systems, which participants believe is now only happening because of the mass removal of low-income families from NPU-V.

Housing Disinvestment

Participants in Phase II articulate housing disinvestment in terms of poor maintenance, which contributes to the presence of rats, roaches, leaks, and sewage. One of the most common mechanisms through which indifference contributes to poor mental health outcomes for this group is poor maintenance. Participants believe that AHA does not care about them, which leads to the lack of response to their maintenance requests. One participant described leaks in her apartment and sewage on her porch as she discussed her photograph "Water Leaks." (see Appendix H)

> *So I have to keep mopping. I had to mop up water every day. And I called and complained about it, but they didn't do nothing. It's just leaks all over the floor. I have to mop so much. Like if I mop the floor one day, I have to come in and mop it again in that particular spot because it will be so wet in there and I don't want my children to fall. [014]*

She continued to discuss her sewage problems.

> *My plumbing is stopped… y'all need to come fix it. And it would take them for weeks and weeks to come fix it. And there would be do-do all over my porch or pee, all that stuff, tissue. [014]*

Other participants talked at length about rat infestation prompted by a photograph of three rats entitled "Rats Gone Wild." (see Appendix H)

> *I had complained to the rent office and he [another participant] will tell you, he killed like 13 of them in front of my house one day. I kept complaining, kept complaining. I had even bought some rat poison and put it down in the holes. They were like I couldn't put the rat poison down because the kids might come and eat it...I had mice climbing on top of my stove and they're eating food… She [another participant] will tell you, she wouldn't come in my house because it was infested with rats. [015]*

One can sense the frustration that the above participant experienced as a result of the rat infestation. She continued:

> *I kept bugging, I kept calling…Everybody went up there, me and another resident kept complaining and kept complaining. When Ms. X was there I told Ms. X to*

come in and see where the rats had ate a whole in my wall. Do you know what she said? Baby, I'm scared of them. I wouldn't go in there either. And I said I don't want to live like this. And I complained and complained. Everybody that was up there knew I had a problem with rats. Everybody came and went, Ms. X, Ms Y… [015]

These narratives demonstrate that residents were contending with poor living conditions at the McDaniel Glenn property. And, although residents were expending large quantities of energy trying to address these problems, there was a lack of response from AHA and its management company. According to participants, this lack of response is indicative of both indifference and the mechanism—housing disinvestment—through which indifference operates.

Member Checking Results

When asked in the member checking meeting if poor maintenance and poor living conditions were major themes, all participants agreed. When asked why, one participant stated.

Because, they are really slumlords in a nutshell… It [A maintenance issue] will be a minor thing, but when they get to it, it's a major thing and then they try to blame it on the residents. If we call you time after time over and over…no return call or you have to keep on calling and I'll get back to you. You don't get back to us until it's convenient for you…that's not fair to the kids nor us because we pay rent. Let us miss one month's rent, you ready to evict us but you not ready to evict the rats and roaches and the broken refrigerators that spoil our food. [016]

The theme of disinvestment was prominent in both Phase I and Phase II dialogue sessions. In Phase I, participants focused on disinvestment related to neighborhood conditions and included lack of city services. In Phase II, participants focused on disinvestment related to housing conditions and included lack of maintenance by AHA. This mechanism of disinvestment combined with speculation leads to the poor neighborhood and housing conditions in the neighborhood, which is described below.

Speculation

After years of disinvestment in the neighborhood, participants describe the extensive levels of **speculation** fueled by cheap land prices and the neighborhood's potential for quick and large profits via the real estate market. Some of this speculation is being driven by the forthcoming 2.8 billion dollar development project known as the BeltLine (Atlanta BeltLine Inc. 2007), a system of parks and light rail that will encircle the city's core.

> *A lot of people, like I said, are coming in due to the BeltLine, due to the area is changing and the growth and the potential that a lot of people see over here. [008]*

Other participants questioned what might be causing the widespread speculation happening in the community.

> *There's literally three or four homes along that same street… that all have for sale signs. And I'm thinking to myself these developers, they must know something we don't because when are they coming? I mean you're building these big homes and those homes are not affordable, by the way. I don't know who, they're not affordable. So, who's coming? Who is going to live in those homes that they're building? [012]*

In response to this question, one participant stated that White people are coming.

> *Those people [who are coming] are White people. They represent White people. They represent people of privilege, of money. And what I think is…our community feels like if we get White people in, then that would have some impact, some greater impact on our quality of life. [012]*

Another participant stated that people with higher income are coming.

> *People that might be able to afford $1600 a month, $250,000, 35 foot wide houses. Somebody has projected that they're going to come and buy these houses. Somebody is projecting that. That's why the boom is on…Somebody has projected, and then what happened is these things are going up and they're standing empty until those people that they projected to come into our neighborhood arrive. [005]*

And yet another participant speculated that more developers are coming.

They're [more developers] are going to come and build some more homes. But those [who have been here] are being pushed away. They can't come back. But the developers are building, and they're coming back building more and nobody is staying there. [001]

Part of what disinvestment does to a community is devalue the land, as participants have noted. Because NPU-V is close to downtown, the airport, and major expressways, it has immense potential real estate value especially given that three NPU-V neighborhoods border the proposed BeltLine. However, the land is currently cheap, and as a result speculative development is noticeable. There are many instances of new homes that are vacant, some with real estate values that are much greater than the community's current income levels can support. There is evidence that mortgage fraud also exists in the community. One of the zip codes in NPU-V (30310) has one of the highest mortgage fraud rates in the United States. As speculators wait for the market to improve, the vacant homes attract vandalism and other criminal activity. The combination of disinvestment and speculation combine to create the poor neighborhood conditions about which participants repeatedly expressed concern.

Poor Neighborhood and Housing Conditions

Participants talked extensively about the poor conditions in the neighborhood, such as the proliferation of vacant and abandoned properties, trash, disrepair and vandalism. These conditions were many times discussed in the context of the speculative development occurring in the community.

And what's really happening here is so many developers are trying to buy up the property over in our communities, but the homes aren't being filled at the rate that they're buying the properties or the homes, like a speed and scale thing. So, these houses are vacant and a lot of times they're getting broken into and they're being vandalized. [008]

Both young adult participants raised concerns related to reduced pride and safety as a result of the vacancy and trash in the neighborhood. One of them stated her concern as she analyzed her photograph “Nice House for Bad Use.” The picture is representative of the many new yet vacant and boarded up houses in the community (see Appendix H).

> *This [a vacant house] is a major concern because I have recently been approached by a stranger that almost led to an assault. And I have seen him come out of this house. [010]*

The young adult participant who titled her picture Walk of Shame discussed her feelings of not wanting to invite friends over because of the trash in the neighborhood. Another participant responded to her narrative by identifying with her feelings of shame.

> *I remember being your age and growing up in Peoplestown and this was before people got together and really did the clean ups that take place. And I felt that way. I felt shameful about where I was from and where I lived, and so much to the point where I didn’t want people to come over and I didn’t want to say that I live on this side of the stadium, but instead to push it back all way to Grant Park, where it was a little bit cleaner… I mean I’m just a little bit older than you, so for you to have that title as your picture says to me that we really haven’t made that much progress. And that’s not a good thing. It’s just really is not a good thing. And we’ve really, we have to do more because perception is reality. And the more that you the youth growing up see the trash around you, shame is what’s going to come out of it. [012]*

These narratives speak to the impact that these neighborhood conditions have on young people’s emotional well-being. During this project, two teenage girls were sexually assaulted in the Pittsburgh neighborhood on their way home from school. Both assaults took place in or on the premises of a vacant property. Not only do these abandoned properties foster criminal activity, they constantly remind both children and adults about potential dangers. The shame of living with such poor conditions is also detrimental to emotional well-being.

Because of these threats related to vacant properties, residents are hostile toward people who squat in vacant properties. In their estimation, many of the people who squat are drug users who are responsible for the vandalism that they witness.

> *Anything that they [crackheads] have found vacant, new, old, used, whatever, they make it a home. They intrude on somebody else's property. You see at some point this building was boarded. They took it upon themselves to go and take the boards off of this property, start staying in it, doing whatever it is that they do in this building… Then they make it a high risk for anything, our children being abducted, somebody being dragged in and raped or killed…[011]*

Although "crackhead" is a perjorative term used to refer to people who abuse crack cocaine, I include it here because it was the language used by this participant. Another participant brought a more structural interpretation to the presence of drug users who use the abandoned structures in the community.

> *When you're an addict and you're suffering from an addiction and you're trying to get a fix, and if you can't do it out in the street because you're afraid you're going to get arrested, you don't have a place to go, you don't really fit into society, and you're hungry, you need shelter, you go and find an abandoned building or a vacant house or something to get high, to seek refuge for that night, and just basically just a momentary fix, like everything else in your life. [008]*

For residents in this community, the hostility toward drug users may represent norms about acceptable behavior. However, drug users may also serve as a target for the frustration that residents experience as a result of chronic poor neighborhood conditions and their failed attempts to make a significant impact on these conditions. So, although residents recognize the larger structural forces that impact community well-being, such as disinvestment and speculation, they also recognize their limited power over the complex bureaucracies (e.g., government, lending institutions, real estate and development interests) and laws that support these forces.

Displacement

The other mechanism through which indifference operates to create poor community well-being is through large scale highly disruptive **displacement** of people far from the neighborhood as described by this participant as he analyzed his picture "Crackhead Haven." (see Appendix H)

> *Instead of relocating them folks from McDaniel Glenn, they could have relocated them to right there [referring to an abandoned building in the community]. They're still in the same NPUV. They ain't got to go far. Their children could still go to the Dunbar Parks, Southside, whatever schools they went to. They still in the community instead of moving these folks out to Dekalb County, Gwinnett, and some other places. [004]*

This displacement has broken social ties that are important to community well-being as discussed previously. One participant, in particular, talked at length about her sense of loss related to displacement as she analyzed her photograph "Emptiness" of the demolished McDaniel Glenn site (see Appendix H).

> *And it's telling me that all those things that were there…family, community, leaders that helped us during our struggle, those that are familiar with it that helped us to get from point A to point B… These are some people that we've seen and don't see anymore…it's no more. There's nothing here. There were homes, family, and a community… It relates to our lives today because there has been family, kids, as well as a love for a community has just not been here no more. It's not here no more. [016]*

Another participant expressed her bewilderment about the people who are no longer in the community and her sense of urgency about keeping those who remain.

> *So what happened to those people? What's going to happen to us? Where are these people? Where are these people? And that's what I talk about all the time. If we don't hurry, we're not going to have anybody to serve or save or do anything,…Where are these people?[005]*

The narratives above refer to the mass displacement of families out of McDaniel Glenn and other public housing communities. In the first narrative, the participant asserts that

the vacant properties in the community could serve as homes for people who used to live in McDaniel Glenn. Both narratives support what was stated earlier—that some people in this community desire to remain connected to their neighbors, friends, and families that used to live in public housing. At the same time, they desire improvements in housing and neighborhood conditions.

To do the latter, participants have admitted to participating in approving redevelopment plans that ultimately served to displace members of their kin network. Participants expressed feelings of being sold redevelopment plans that they thought were good, later realizing that current residents were not going to benefit from them. After years of disinvestment and speculative development that created extensive blight in the neighborhood, residents seemed to invite development that they thought would make their neighborhoods better. However, instead of development for them, they soon came to understand that the development was intended for others. As stated earlier, these others include White people of privilege.

> *When they [developers] brought it [the development plans] to them [residents], it was good. They thought it was good anyway. They thought that they would get a lot of benefits from it. But when reality kicked in and the plan went on the table, a lot of people are not the ones that are coming back. And it's heavy because we still deal with these people every day…How are they going to be able to make it with fair market rent? [011]*

Participants also expressed their own openness to others moving into the community because of the potential benefit of having people with more resources living with those with fewer resources. However, in their estimation, this openness has led to displacement.

> *We assume that with the idea of developers coming in and building up homes or houses or building up our community it's going to be better and a better group of people, a more acceptable crowd of people are going to come in and it's going to*

> *like somewhat uplift the value of that community. But for the most part, like I said, you have a whole bunch of people being displaced out of their homes. [008]*

They also expressed believing that relocation was a temporary solution until the revitalized property was erected, allowing residents to come back, as reflected in this comment:

> *I think it's wonderful that they're tearing them down and rebuilding them. And a lot of people are going to be able to come back. [018]*

These quotes remind me of the general consensus in research that poor communities of color are distrustful of outsiders. In my estimation, people do ask many questions of developers and other outsiders that demonstrate some distrust, but in general people will approve many of the development projects that are brought before them. I asked the group why this was the case, and a participant replied, "What is our other hope?" Years of disinvestment has thus served to create conditions that compel people to accept development plans for the betterment of a community that they will no longer be able to live in.

In the narrative below, a participant provided reasons for the widespread displacement of residents out of NPU-V. In his view, there are two driving forces—traffic congestion and suburbanites' desire to be closer to their jobs. He described parts of the neighborhood that are not yet redeveloped as looking like another low-income community called Bankhead and the newly developed parts as resembling a high income community called Buckhead.

> *What I was fixing to say is really what is going to eventually happen, if you look right down here, I don't know who all is familiar with the Canterbury Area. But if you come out of Dunbar Center and you make a right and go straight down to the next set of stop signs you see, look at that side of the street, then look at that side of the street. This looks like Bankhead, that looks like Buckhead [laughter], you know what I'm saying. What they really are trying to do is make it where it won't*

> *be that much traffic where they won't need them 24 lanes. What they're really trying to do is push us out of this community and bring the other folks, the upper class, middle class folks that have done moved out there to Gwinnett County and all that, bring them back from the suburbs where they will be closer to their job. [004]*

Another participant articulated that the reason for displacement is related to all the amenities and entertainment options near downtown.

> *Say you're working and you're not on an income like AFDC… They're not going to let you in unless you're doing something constructive because of the community, it's built around the stadium, it's built around Phillips Arena, it's built around all those things, like the aquarium, and all those things that are downtown. And most of the things that they're building up are $170,000 or $220,000, things that people cannot afford if you're living on a low income. And so they're not going to let them back in. If you don't have the money that talks, the money that walks. [016]*

In addition to the issue of indifference, participants attribute displacement to the mobility of White suburbanites who have moved away from the city to the suburbs, a phenomenon known as "white flight," and are now moving back to the city to be closer to their jobs and downtown entertainment options, a phenomenon referred to as gentrification. The mobility of Whites is a factor that participants believe contributes to poor community well-being. The mechanisms through which this factor operates are the same as those through which indifference operates. The mechanisms are disinvestment; speculation; the poor neighborhood conditions that disinvestment and speculation create; and displacement. When participants were asked to create a label for these mechanisms, one participant offered "powerless transitions," a term that resonated with the group. In effect, participants believe that the dynamics that are occurring in the community are outside of their control.

Research Question 4:

What do Residents Perceive as Potential Facilitators and Inhibitors of Improved Health Outcomes?

Residents perceive that some of the potential facilitators of community well-being are **organized residents**, greater **church involvement** in the neighborhood, and **greater accountability** on the part of politicians, developers, and other institutions. The major inhibitor discussed by participants is the lack of caring by people inside of the community. This lack of caring might be best described as **apathy** evidenced by feelings of defeat, tolerance, lost hope, and tiredness. These facilitators and inhibitors were mostly identified within the context of the Phase I discussions.

Potential Facilitators

Church involvement

Participants believed that if churches were more involved in the community, they could make progress toward improved community well-being. Participants noted that the people who attend church in the neighborhood no longer live in the neighborhood and are therefore not involved in the life of the community. This participant expressed the need for greater church involvement in her photograph "Congregation versus Community: How Many Churches Does it Take?" (see Appendix H)

> *Well, I just feel like our neighborhoods are really in need of support of all of the organizations that are in the neighborhoods, of all of the resources that come out of the neighborhood. And churches are our resources that we need. And so I feel like we won't have the capability if we uplift all the other organizations and say let's work together and then the churches still operate in their own parameters... The churches are in the community, they should know community should participate in the community. [012]*

Some participants talked about the ways in which communities and churches connected in the past. In this narrative, this participant described how churches assisted community members with basic needs such as groceries, finances, and clothing.

> *It wasn't such a thing then because if you didn't have, they [the church members] all came together. When they came and unloaded you had groceries, finances, clothing, etc. [011]*

This participant talked about churches in the past being a source of spirituality.

> *Spirituality fed them [Black people] through an era where like I need to fight for my rights. They're telling me I can't vote. I have to go to different like schools, not to the same restrooms…[008]*

The disconnection between church and community did not happen solely because churches pulled away. In the context of their narratives, the above two participants talked about community members also separating from the church. One participant stated that Blacks, who depended on the church as a means of social support during the Jim Crow era, no longer needed the church due to increased civil rights. The other participant stated that Blacks have become more and more embarrassed about lacking resources and therefore refuse assistance from the church. In general, participants believed that reconnecting churches to the community could be a facilitator of neighborhood change.

Accountability

Participants, in general, talked at length about accountability—their own and that of those who serve the community. They talked about holding people who impact their lives accountable as a potential facilitator of community well-being. Examples of those to be held accountable are state representatives, city of Atlanta representatives, policymakers, and developers, as described by this participant.

> *Ensure that people, people being policy makers, developers, are held accountable for building in our communities and that they continue to ensure that the housing that is being built is affordable. [012]*

In keeping with the previous discussion about church presence in the community, this participant stated that the community needs to hold churches accountable for their physical presence in the community being divorced from their commitment to the community.

> *I just feel it all goes back to accountability, the accountability of us, the residents, the members of these organizations to hold to, am I saying that right? Yeah, to hold the churches to because at some point we have to, we have to say this isn't okay. If all of your congregation consists of people from Athens, it doesn't matter. You are here in this neighborhood. And if you are not a part of the growth and the development and the cleaning up of the neighborhood, then you might really need to reconsider where you need to have your church. [012]*

Residents also recognized their own accountability as it relates to creating a healthier community.

> *So, it's like we have responsibilities, they [neighborhood leaders] have a responsibility. I'm not going to scapegoat my part in it, but I'm not going to scapegoat their part. I think we all have an accountable part to play in it. [008]*

While the dominant view may be that people in low-income Black communities don't take responsibility for their lives and their communities, residents repeatedly expressed their conviction about their own role in improving conditions in the neighborhood.

Organized Residents

Participants used words such as organize, rise together, and rally together to express that if residents organized, they could accomplish what one person cannot do alone.

> *The community needs to rally together and get behind each other and go to some of these construction sites and tell these folks to hire us. And that's what we can*

> *do about it, get together as a group of people and rally, march, protest, do something to start like going down to the construction site. [004]*

This participant felt that it was residents' responsibility to organize in order to prompt the City to remove the trash.

> *I just want to say you as a resident can organize on that. You can ask your neighbors to call. If they start getting enough calls and stuff, people staying active around there, they'll get up and move that trash. That trash won't keep sitting there. That's all I'm saying. You have to take responsibility too as residents… You can't wait for nobody else to do nothing for you… Knock on some of those doors on that same street and organize about, get them people to start calling downtown. [001]*

Another participant suggested that the community use its leverage to get things accomplished. For example, if a developer needs approval on a project, there are some requirements that can be put in place.

> *We have made the calls and the numbers don't work. So, for us as a community, NPUV, to take action on some of these dumpsters that we see sitting, can we go just say to [our civic association], "Okay, the developer came to the meeting, he told you what he's willing to bring to the table, what he wants to do. So he had to leave y'all some kind of contact information to be there… Okay. Your dumpster has been here, it's overflowing, it's blocking traffic signs, and it's making our neighborhood worser than what it is… He's got to either move this dumpster, or you need to have it where he can get fined for not moving it because we're not going to keep dancing around this." [011]*

This participant stated that organizing should be a strategy that the community uses not to participate in the usual process of calling the City, rather to do what it needs to for itself.

> *Why can't we just move it [the dumpster]? I know that's a very simple question, and I know it's so much deeper than that. But really, if we're sick of it, if we're getting the run around when we call, and I don't mean we individually, I mean we collectively, why don't we just say "You know what? Enough is enough. I'm sick of this. I'm tired of looking at. The city won't answer the phone. I'm getting the run around. And you know what? I'm about to start loading dumpsters up and putting them somewhere else." [012]*

Together, these narratives demonstrate that some residents believe that if they organized, they could create the leverage needed to begin reversing the conditions in the neighborhood.

However, one participant disagreed that an organizing effort, like a calling campaign, would work.

> *I don't think it [a calling campaign] really works because I just moved to the Grant Park area, which is an area that they really try to keep up. And there was a dead rodent and they were like call the City. We called for at least three months and it never got picked up by the City. And when they finally did come to pick up the rodent, the guy up the street had already did it. It was a neighbor, somebody who just was tired of it. [002]*

The above participant also alluded to the fact that Grant Park is close to NPU-V and used to be like NPU-V until it gentrified. She suggested that the City might still believe that Grant Park is a bad part of town. There were others who expressed similar doubts about organizing based on their past experiences, but there were participants in both phases who believed that organizing was one strategy that could create change.

Inhibitor

Apathy

In contrast to outsider indifference, participants noted that people inside the community experience apathy. This apathy is expressed in the following statements about being tired, losing hope, tolerance, being comfortable, and feeling a sense of defeat. As she analyzed her photograph "What's the Buzz?" (see Appendix H), this participant states:

> *Why does this exist? We got tired. We stopped coming to the table to voice our own opinions about where we stand. [001]*

Another participant speculated that people may feel a sense of defeat because of the longstanding conditions in the neighborhood as well as residents' failed efforts at creating the changes that they desired.

> *I think we feel a sense of defeat. I think that we feel like, I mean when I say we, I mean we collectively feel like it's been like this, it's going to be like this…And so if you have people who have been around for the decades to see the stuff still happening, how are you going to get them to go talk to politician so and so when they already know it's been going on for decades. So it's a sense of defeat. It's a sense of I've tried this, it hasn't worked. [012]*

Some participants believe that this apathy is a value that people have in this community, a value that is different from the values that others have.

> *That lady knows that her house is in shambles, why would you continue to pay rent for something like that? I know everybody is not always in control of their own situation. They may not be financially equipped. But I just have to think about our value system because some people's value system is much different from ours. When they own their house, they want everything to be top-notch, everything up to par, versus people who rent homes out of the area, they really don't care and they just think, oh well, I'm just paying my rent [003].*

One participant suggested (through her question) that Blacks actually brainwash themselves into apathetic thinking. She made this comment in response to her photograph entitled "Too Hood to Care." (see Appendix H)

> *And why does the situation or concern or strength exist? Because are Blacks brainwashing themselves into thinking that there isn't a way out?[003]*

Another participant suggested that this apathy comes from an external factor that teaches tolerance and wears down Black people.

> *You have to understand how we are taught in this country. See, we are taught to tolerate in our communities. We're taught to take care of other people's communities. It's really in your blood to do that. So until the day that you become conscious and take that same blood and exercise the pride that you have in somebody else's stuff in your stuff, then you will see a difference [005].*

According to participants, it is this apathy that is partially responsible for the conditions in the community. Although participants in Phase I named apathy as a condition afflicting many residents, the type of apathy that they described may be that associated with involvement in formal neighborhood processes such as monthly NPU-V meetings. When considering the dimensions of apathy during axial coding, I considered the locus of apathy. That is, the expression of apathy could range from being directed toward all areas of one's life to no areas of one's life. As I analyzed the Phase II transcripts, it was clear that while participants in this group did not attend monthly NPU-V meetings, they were not apathetic in other areas of their lives. Participants sought out assistance from neighborhood organizations and the Atlanta Housing Authority. They described the many requests they made to the management office for assistance with housing problems. They created petitions and contacted the local NAACP and television stations.

In the context of "not caring" or "apathy," participants raised the issue of tolerance. This participant stated that outsiders don't care about the community because they believe that insiders will tolerate poor conditions.

> *To me to leave something half done is to say that you could really care less and that you think the people in the community could really care less. And she [another participant] said it perfectly when she said tolerate. Because outsiders think that we tolerate and don't care, that we just don't care. [012]*

This participant was adamant that this community tolerates too much.

> *What it is is that they know that we will tolerate the trash. We will tolerate you tearing down a house and leaving the dumpster in the middle of the street for 1500 years. We will tolerate a half paved road. And I'm just going to end it right there. Toleration. [005]*

There was a lively debate in Phase I about whether or not residents tolerate the neighborhood's conditions after a participant made this comment.

> *I believe that the reason why we continue to see trash just in the community in front of an abandoned property, not in front of abandoned property, on corners, on empty lots is because there has to be a point where we, the residents and the community members get sick of seeing it. And I'm not, this isn't to discount or to say that we in this room aren't sick of seeing it, because obviously we are. We've made it a point to talk about it every meeting. But we collectively have to get sick of seeing it. And if you want to know the difference I believe between our neighborhoods and other neighborhoods when you walk down the street and you don't see the trash, but yet they're doing all this development just like we are in this community, it's because people get sick of it. People won't tolerate it rather. They won't even allow the idea or the possibility of trash in dumpsters being left for months on months on months. It's not going to happen because they say this is my home. I pay money for this every month. I have a car. I have a choice. And they're not going to be exposed to this. So they don't tolerate it at all. And the minute they start to see that, you'd better believe they are raising sand somewhere somehow to somebody. And I'm not saying that we don't do that, so I don't want that to be the takeaway. I'm simply saying that we collectively need to get behind it and really be the voice that says we don't, this is not cool. This is not okay. And I don't know that we have those kind of numbers when we go and we say this is not okay. I don't know. That's my speculation [012].*

The above narrative supports the earlier discussion of organizing as a potential facilitator of community change and well-being. However, what I found interesting about this narrative were the many caveats expressed by the participant. This indicated some level of confusion that I was interested in understanding. I asked the group to comment. One participant responded:

> *When I say tolerate or settle for, [it's] because you're letting it happen, but you can do something about it. You just planned on letting it happen. And it's not because they don't have information or resources. Some of them just don't want to do nothing. So that's why I say they just settle for anything or they tolerate it because I know a lot of them can do better. They just like living like that. [001]*

When asked why, the participant responded.

> *It's been like that so long, they've just got comfortable. [001]*

Another followed up.

Or what if they're just out of fight? [002]

Similarly, a participant from Phase II began to say that people at McDaniel Glenn don't care, but then qualified his statement by saying that maybe people do care but they are afraid of not being heard.

We don't care… We care, but I guess we don't want to step up and say anything because we don't think nobody will listen. [017]

Part of what I understand from these exchanges is that people in this community have "raised sand" about living conditions, but they have not gotten the response from the City or AHA that they would expect based on what they see happening in other neighborhoods. Therefore, they must either blame themselves or blame the institutions, and at times they do both. In this dialogue, they point to residents' apathy. However, when asked to explain this apathy, many participants acknowledge the structural influences that might be working to create this condition.

Research Question 5: What Strategies do Residents Use to Mitigate, Resist, or Undo the Effects of these Factors?

Geronimus (2000) describes a set of identity-affirming institutions and social networks that people in poor Black communities have created to mitigate, resist, or undo the effects of structural conditions on their health and well-being. I was interested in understanding what some of these strategies might be. To avoid creating an additional frame for the dialogue sessions, I did not ask residents questions directed at understanding their use of identity-affirming institutions and social networks. Instead, I allowed possible mitigating strategies to emerge from the data. The mitigating strategies

that I identified are more related to individual and group actions used to manage the many dynamics and conditions experienced by residents as opposed to specific institutions and networks. The identification of these institutions and networks could become evident with more in depth ethnographic methods. Below are examples of the strategies that residents named.

Residents described small acts of resistance that they used because they believed that the conditions that they faced were unfair. One participant stated that right before relocation, the management company began fixing up the property in order to pass inspection before demolition. When asked to sign paperwork verifying that maintenance had been completed, she refused to comply.

> *It seems like when its time to tear down the apartments, that's when they want to fix everything, and I refused to sign the letter because when we complained about it, they didn't come out then and do it…They want to go around and have you sign saying that they did this…I been put that in a long time ago…It's time to move, why come and fix it now? [015]*

Even though this strategy ultimately did not impact the larger forces such as the long term disinvestment and demolition that she described, this small act of resistance might have provided her with a sense of empowerment and personal dignity in the face of circumstances that were disempowering. Earlier, I described this participant's thoughts of suicide in response to the many social stressors that she faced, including rat infestation that was very overwhelming. So, this is a striking example of how a person facing dire social circumstances asserted her own power and affirmed her own worth.

Participants in this group also talked about their many efforts to collectively work together to create change. This participant created a petition and networked with others to bring attention to the poor living conditions at McDaniel Glenn.

I got a petition because of the mere fact that they tried to throw us out and not give us anything. Then I made a petition for us for them not doing what they were supposed to do as far as the clean up of the apartments, the mold and mildew. [016]

Although residents tried to organize to create change, ultimately their efforts were unsuccessful in changing their living conditions, but these actions demonstrate that some residents actively try to mitigate the circumstances that they face.

The lady that lived in the back of us, she had the NAACP to look at the petition and letter that she typed up. She sent it to the mayor. The NAACP, they said they couldn't help, we needed to call channel two or somebody. They did that, and they left a message, no one ever called back. [015]

However, if residents continue to experience failure after attempting to create change, there will be little incentive to continue future efforts, which may be part of the reason why some residents believe there are high levels of apathy among many NPU-V residents. In one of the dialogue sessions, a participant suggested that the group try again to create a petition. However, one participant noted that there was little success before, and she doubted that it would work this time. This quote demonstrates the "giving up" or apathy noted earlier under research question number four.

I don't think that [a petition] will work because we done did that about four or five times. Done did that about five times... Everybody signed that petition. It didn't do no good. [014]

Residents also felt like there was retaliation whenever they attempted to organize as expressed in this dialogue between the facilitator and two participants. Therefore, the sense that people have given up may sometimes be more related to their fear of retaliation than apathy.

We just got threatened. Throwing us hints. [016]

And what were they saying? [Facilitator]

Oh, we're going to move somebody around and then you can send people in our houses. [016]

To look for what? [Facilitator]

A reason to put us out. [015]

Participants also sought help from the various organizations in the neighborhood, including the very institutions that they believed to be responsible for the negative neighborhood and social conditions. For example, this resident described the number of times that she sought help from the management office about the conditions in the apartments.

I kept bugging, I kept calling. They started calling me [by my nickname] at the maintenance office because I complained. Everybody went up there, me and my neighbor kept complaining and kept complaining. [015]

Residents also stated that they tried to cooperate with AHA's requirements as a strategy to manage the many rules and threats of housing loss.

We try and comply every way you [Atlanta Housing Authority] ask us. It's not like we're not trying to do what you ask us. [016]

Even though residents used resistance and organizing to work outside of the system to create change, they also try to use the established procedures as a mitigating strategy.

What the themes above indicate is that residents of this community use several strategies to manage the poor living conditions and the many institutional dynamics taking place that support the conditions in their neighborhood. While some residents use more formalized networks, others create their own linkages to advocate for change. However, as these networks continue to fragment due to displacement, the ability of residents to maintain social ties and advocate on their own behalf will also continue to decrease.

Summary of Results

The following table summarizes the themes that were developed in response to the five research questions.

Table 2. Study Results

Research Question 1: What do residents of NPU-V perceive to be their priority health outcomes? Poor community well-being characterized by: • Fewer community places • Reduced levels of connectedness and relationships • A lower level of concern for each other • Fewer indigenous caretakers Poor mental health characterized by: • Stress and hopelessness • Alcohol use • Suicide ideation
Research Question 2: What do residents identify as factors that contribute to poor health outcomes? Indifference expressed by people outside of the community as a result of their negative perceptions about the community based on race and/or class bias.
Research Question 3: Through what mechanisms do residents perceive that these factors operate? • Neighborhood and housing disinvestment • Speculation • Poor housing and neighborhood conditions • Displacement and broken social ties
Research Question 4: What do residents perceive as potential facilitators and inhibitors of improved health outcomes? Potential Facilitators: • Organized residents • Church involvement in the community • Greater accountability Inhibitor: • Apathy
Research Question 5: What strategies and resources are currently being marshaled to mitigate, resist, or undo (Geronimus 2000) the effects of these factors? • Resistance • Help-seeking • Organizing • Compliance

The themes identified for research questions one, two, three, and five form the basis of the explanatory model that will be discussed in chapter five. The analysis of

inputs from participants revealed that the key factor leading to poor community well-being and mental health, which are the health outcomes of interest identified by the participants, is indifference. Indifference is an expression of apathy, lack of concern, and disengagement or "emotional distance."[2] Specifically, participants view outsiders as possessing an attitude of "not caring." These outsiders include White Americans, middle class African Americans, developers, and the institutions that some of these groups represent such as the City of Atlanta and the Atlanta Housing Authority.

Based on participant input, "indifference" contributed to four core mechanisms and their related conditions that undermine community well-being and mental health. These four mechanisms are neighborhood and housing disinvestment, speculation, poor neighborhood and housing conditions, and displacement and broken social ties. Residents use strategies to mitigate these dynamics, but their efforts are comparatively smaller than the larger social forces impacting the community.

[2] The American Heritage Dictionary of the English Language, Fourth Edition copyright ©2000. Updated in 2003. Houghton Mifflin Company

CHAPTER 5

Discussion

Introduction

Prior to undertaking this dissertation, I would have agreed with Griffith, Moy, and colleagues (2006) that health disparities have been well described and well documented, but not well addressed. I would also have stood in solidarity with Nicole Lurie (2005) in her call for less talk and more action in reference to disparities in health. In some senses, I do still feel a sense of urgency when it comes to intervening on the factors that contribute to racial/ethnic disparities in health. However, acting on incomplete models may serve to further stabilize disparities. As stated in chapter one, there are a limited number of studies that attempt to understand and explain the fundamental causes of racial/ethnic disparities in health from the perspectives of those experiencing disparate health outcomes. In general, research follows the positivist paradigm of knowledge creation which begins with theorizing by the researcher followed by tests of the theory in populations of interest. In this study, I attempt to begin with the perspectives of residents of a poor to moderate income neighborhood in urban Atlanta to propose a model of fundamental causes of poor health outcomes rooted in their lived experiences.

Community-based participatory research is an approach that supports this mode of theory-building because it aims to begin with a research topic of importance to the community (Israel, Schulz et al. 2003; Minkler and Wallerstein 2003). Similarly,

Photovoice is a research methodology that engages participants in defining issues of importance and intervening through presentations to policymakers (Wang 1999). This dissertation study used both a CBPR approach and the Photovoice methodology to create the data for analysis. By including residents' perspectives in a significant way, this study aims to expand existing models such that they become more robust and better able to guide research, practice, and policy-making.

Although residents did not decide a priori to use a fundamental cause framework, their responses to the SHOWeD question "why does this situation, strength, or concern exist?" and the discussions that followed point to underlying factors, which I, in turn, equate to fundamental causes. I do so because the factors that residents identify adhere to the two attributes of fundamental causes proposed by Link and Phelan (1995)—that is, they influence multiple risk factors and multiple disease outcomes. Link and Phelan (1995) also propose that an essential feature of a fundamental cause is that it involves access to resources that can be used to avoid risk or to minimize the consequences of disease once it occurs. This feature aligns well with SES as a fundamental cause and other ways of framing fundamental causes in terms of money, power, and prestige. However, this economistic framing is less helpful when conceptualizing a fundamental cause as one that shapes outcomes such as community well-being and mental health through the creation of unhealthy physical and social environments and dynamics, which are less about individual SES and what that SES affords in terms of preventing or intervening on a specific health outcome.

Overview of Explanatory Model

In this section, I provide an overview of the explanatory model that I developed based on the themes identified in chapter four, followed by a more detailed explication of the model's components and related literature. This chapter will then close with a discussion of the study's strengths and limitations, validity of findings, and implications for public health research, practice, and policy.

Participants used simple 35 mm cameras to document a range of important health and social issues, and through group dialogue began to uncover and describe the root causes of these issues. Through grounded theory analysis of the transcribed dialogues followed by two member checking meetings, I developed a model of fundamental causality that is a good fit for this context and possibly for many contexts in which poor African Americans find themselves. I use the words "find themselves" deliberately to evoke the sense that many poor African Americans are unlikely to determine where they live. According to the model, displacement is a fact of life for poor African Americans in NPU-V, a factor that is not well understood in the context of health and health disparities.

Residents of this area also place displacement in the context of other social factors that are known to impact health such as poor neighborhood and housing conditions. Further upstream are factors such as indifference driven by negative perceptions of low-income African Americans that are part of the prevailing ideology. According to participants, these negative perceptions and the actions that follow from them are institutionalized in policies enforced (or not enforced) by Atlanta city government and the Atlanta Housing Authority, the two institutions that they understand to be contributing to

poor housing and neighborhood conditions and broken social ties. This phenomenon of indifference fueled by negative perceptions might otherwise be known as institutional racism, although this language was not used by participants, with the exception of one participant who is heavily involved in planning anti-racism workshops in the community and is thus attuned to this terminology. Why participants, in general, do not use this terminology is beyond the scope of this dissertation, but I speculate that it is related to the silencing of racism arguments that I discuss in the section below on White Mobility and Indifference.

The explanatory model (Figure 1) depicts concentric spheres of fundamental causes (the spheres entitled "macrolevel factors" and "white and middle class black indifference and white mobility") and the resulting mechanisms that contribute to the health outcome of interest in the center of the model. Although I used a linear model as part of the member checking discussions with participants, I reconstructed the model as a series of concentric spheres after the meetings to more clearly depict an ecological framework and to illustrate the magnitude of the social forces impacting residents of NPU-V. The drawback of these concentric spheres is that they limit the ability to demonstrate how each factor is explicitly connected, which would aid in a better understanding of assumptions and relationships.

The outermost sphere describes the macrolevel factors that contribute to the mobility and indifference in the next sphere. These macrolevel factors include historical conditions such as slavery and Jim Crow laws, economic and social systems like capitalism and institutional racism, as well as prevailing ideologies such as the belief in racial superiority and inferiority. Because of the belief that Blacks are inherently inferior,

participants in this study believe that Whites feel indifferent about them and their community, which is depicted in the next sphere. In addition, Whites who have moved to the suburbs are now looking for opportunities to be closer to their jobs; therefore, their mobility is creating the pressure that ultimately impacts residents of NPU-V. Both the mobility and indifference that participants name are institutionalized in government policies that support White Americans' mobility and in ideologies that support their indifference. In the same sphere is the indifference of members of the Black middle class who are now in positions of authority in city government and the Atlanta Housing Authority and who have moved out of low-income Black neighborhoods. According to participants, this group of people used to live in neighborhoods like NPU-V but have been able to elevate socio-economically and move out of the neighborhood and into the suburbs. These African Americans have since become indifferent about NPU-V and its residents. Participants believe that the income disparity between these Blacks and themselves is the primary reason for this indifference. Again, this indifference is supported by macrolevel factors, such as institutionalized racism as well as internalized oppression resulting from the history of slavery and Jim Crow in America.

The next sphere describes a trio of mechanisms through which indifference operates to create poor community well-being and poor mental health. They are disinvestment, speculation, and displacement, involving the local government, developers, and one of the largest owners of property in the city—the Atlanta Housing Authority. These mechanisms (which might also be conceptualized as fundamental causes) contribute to the conditions found in the next sphere. These conditions relate to the built and social environment. The built environment includes poor neighborhood

conditions such as vacant housing, trash, disrepair, and vandalism and poor housing conditions such as leaks, sewage build up, rats, and roaches. The social environment includes broken social ties as a result of displacement.

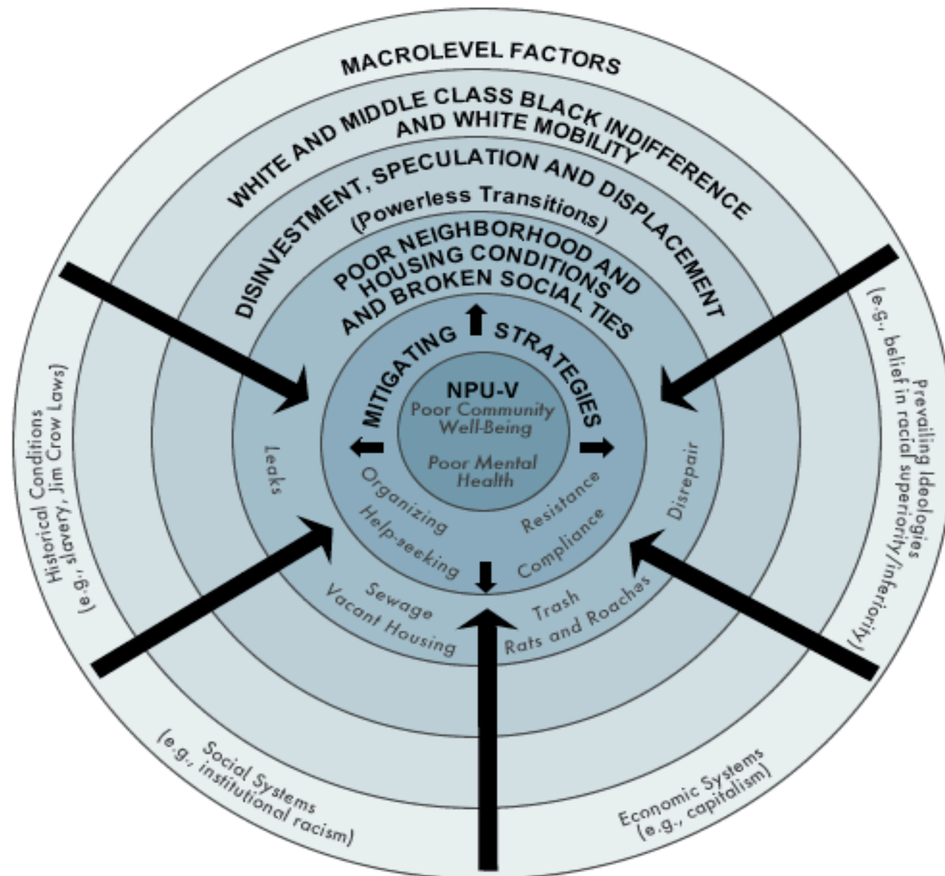


Figure 1. Fundamental Causes and their Mechanisms and Outcomes

The innermost sphere represents the NPU-V community, which has been impacted in two ways—poor community well-being and poor mental health—as a result of poor neighborhood and housing conditions and broken social ties. The sphere adjacent to the NPU-V sphere describes the strategies that community members use to mitigate, resist, or undo the effects of the above fundamental causes and their resulting mechanisms and conditions. These strategies, such as help-seeking, resistance,

compliance, and organizing are represented by small arrows projecting outward, while the large arrows pointing inward toward the center reflect the relatively formidable impact of the fundamental causes and their mechanisms on the community.

Model Components and the Related Literature

Macrolevel Factors

Participants in this study stated that outsiders' negative perceptions of them led to feelings of "not caring" or indifference. However, participants did not frame these negative perceptions in terms of macrolevel factors. This is language that I brought to the model based on work by other researchers (Geronimus and Thompson 2004; Schulz and Northridge 2004). Geronimus and Thompson (2004) point to racialized ideologies that influence the poor health outcomes of African Americans. One of these ideologies is the American Creed, which asserts the fairness of U.S. institutions. Geronimus and Thompson (2004) state that this belief in fairness and the equality of opportunity leads many Whites to the racially prejudiced stereotype that Blacks are lazy and culturally disposed toward poverty. These widely held stereotypes ignore other macrolevel factors such as the history of slavery and Jim Crow laws in America, which both serve as part of the foundation for unequal treatment of African Americans. Although participants did not name these macrolevel factors per se, I have included them in the model given the extensive literature supporting their role and how they inform the remaining model components. For example, participants stated that outsiders' feelings of indifference resulted from negative perceptions of Black Americans. These negative perceptions are embedded in prevailing ideologies about African Americans that are borne out of the

historical separation of the races dating back to slavery. Thus, it is impossible to talk about racial/ethnic health disparities without considering these macrolevel factors.

White Indifference

Residents in this study name indifference as a key factor influencing poor community well-being and mental health outcomes. When asked to identify factors that contribute to this indifference, they name negative perceptions based on skin color and income levels. They also name both White and middle class Blacks as having these negative perceptions. What they sense is supported in the literature through studies of the amygdala, a part of the brain responsible for processing emotions, including fear and anger. In a study by Lieberman, Hariri, and colleagues (2005), both Blacks and Whites produced a greater response in the right amygdala to images of African Americans than those of Caucasian Americans. The authors suggest that the amygdala activity typically associated with race-related processing may be a reflection of culturally learned negative association regarding African-American individuals.

In another study of perceptions of African Americans (Davis and Smith 1990), 29% of Whites viewed most Blacks as unintelligent, 44% believed that most Blacks are lazy, 56% endorsed the view that most Blacks prefer to live off welfare, and 51% indicated that Blacks are prone to violence. According to Williams and Williams-Morris (2000), beliefs about the inferiority of Blacks have actively translated into policies that restrict the access of African Americans to educational, employment, and residential opportunities. Similarly, participants in this study believe that these views (held by both Whites and middle class Blacks) have been translated through governmental and housing institutions into poor neighborhood and housing conditions and displacement.

In the present study, participants were sometimes hesitant to name Whites as having negative perceptions of them. They expressed this hesitancy when they retracted statements about White people. An example of such a retraction was discussed in chapter four. This hesitation may be due to the dominant viewpoint that Blacks complain too much, a viewpoint that serves to quiet criticism. I recognized this hesitancy during dialogue because it was familiar. Each time I find myself naming the impact of racism on the lives of poor Black Americans, even if I do so privately as I think or write, I can immediately hear the counter arguments that reverberate through the media and in other settings, such as the classroom. Recently, I lectured on health disparities before a class of Master's students. In response to my analysis of the impact of negative perceptions on low-income African Americans, one White student proclaimed in the form of a question, "Isn't this just the ghetto mentality that Blacks have that the system isn't fair which gives them an excuse not to do anything?"

However, in a study of metastereotypes (i.e., Blacks' perceptions of Whites' stereotypes), Blacks' assessments of White images of Blacks were found to be largely accurate (Sigelman and Tuch 1997). Using data from the 1990 General Social Survey, the researchers compared White stereotypes with Black metastereotypes. With one exception, the data show a general correspondence between Blacks' metastereotypes and Whites' stereotypes. For example, most Whites accepted the image that Blacks prefer to live off welfare and are violent, which corroborated with Blacks' metastereotypes. The only metastereotype that Whites did not hold to the extent that Blacks thought they held them was that Blacks are unintelligent.

Black Middle Class Indifference

Participants in this study believe that middle class Blacks within institutional arrangements also act indifferently toward them. Popular writer Michael Eric Dyson wrote about the stereotypes of poor Blacks held by middle class Blacks in his book *Is Bill Cosby Right or Has the Black Middle Class Lost its Mind?* He wrote this book in response to scathing remarks made by comedian Bill Cosby about poor Blacks in the media. Dyson created the term Afristocracy to describe upper-middle class Blacks and their condemnation of poor Blacks both privately and publicly, although Dyson will agree that even low-income Blacks describe themselves in this way (2005). I found this to be consistent with the conversations in this study. Participants at times described members of their own community as lazy and "acting alley" (i.e., acting ghetto) even as they resist those stereotypes of themselves and point to these stereotypes as a factor contributing to the break down of their community.

Sigelman and Tuch (1997) cite a presentation by Peffley and Hurwitz (1993) in which stereotypes are said to be motivated by an ethnocentric bias to enhance one's group and to disparage out-groups. It appears from this study that low-income Blacks also create these divisions amongst themselves. For example, during a conversation about the conditions in a rooming house, one participant commented "I'm glad I don't live like that" and declared that the people who live there "just don't care because they give the landlord $85 per week." This very same participant was struggling with rats, roaches, and raw sewage in her own apartment for which she paid rent. Because poor Blacks have limited political and economic power, their stereotypes of each other (although an important area of study and concern) are not as impactful as those held by

Whites and middle class Blacks because the latter two have the power (through institutions and institutionalized policies and ideologies) to translate those stereotypes into actions that have the potential to further marginalize poor Blacks.

In her analysis of 19th century middle class African Americans, historian Cindy Aron (2001) observed that middle class Blacks hoped to disprove White racist attitudes if they acted in ways that were consistent with White middle class values. For middle class Blacks, this led to a tension between distancing themselves from lower class Blacks and at the same time feeling responsible for uplifting those Blacks in the lower ranks of society. Although some authors have contested that middle class Blacks have been able to distance themselves from lower class Blacks (Pattillo 2005; Heflin and Pattillo 2006) because of the socioeconomic heterogeneity of Black families as well as the segregation patterns that confine middle class Blacks to poorer neighborhoods, participants in this study do name this distancing as a factor impacting their neighborhoods.

As I wrote the above two sections on indifference, I observed a tension between individual perceptions and actions and the institutional arrangements that support them. While participants devoted much of the dialogue to actions taken by individuals, many of these actions exist within the boundaries of institutions that support these actions. The balancing of structures with the human actions that reproduce them is embodied in the theory of structuration (Giddens 1984). The theory of structuration involves understanding the ways in which social interaction produces social systems. According to this theory, structures are sets of rules and resources that individual actors draw upon in the practices that reproduce social systems (Giddens 1984). So, in the example of the Atlanta's Black middle class-led government, Black middle class actors have drawn on

existing rules about how limited city resources are to be distributed (e.g., to neighborhoods of tax-paying White citizens) to reproduce the social systems that we see in NPU-V.

White Mobility

In addition to White and middle class Black indifference, study participants perceive the mobility of White suburbanites as a powerful force that impacts the integrity of their neighborhoods. The mobility referred to here is the ability of White suburbanites to move into the city's center and thus displace poor African Americans from their neighborhoods. This phenomenon is generally known as gentrification, which is defined as the buying and renovation of houses and stores in deteriorated urban neighborhoods by upper- or middle-income families or individuals, thus improving property values but often displacing low-income families and small businesses (Random House Unabridged Dictionary 2006). This movement into neighborhoods of color resembles another migratory pattern of Whites—"white flight," a term coined in the 1960s to describe the movement of middle class Whites out of neighborhoods undergoing racial integration. Schulz, Williams, and colleagues (2002) argue that this trend toward flight and fragmentation has contributed to the current spatial configurations of race and wealth typical of many urban areas; however, they place this phenomenon within the context of institutional arrangements such as decentralized governments that support policies that increase segregation. Some scholars argue that the overemphasis on white flight obscures the constellation of government policies that drove postwar suburbanization, excising structural analysis in favor of a narrative that revolves around individual racism (Lassiter 2006). A similar argument against the use of the term gentrification could be

used as it focuses attention on individuals' movement into a neighborhood and away from the policies that support this movement.

While participants in this study attribute the displacement pressure to White suburbanites' desire to live near work and entertainment in the city's center, Fullilove (2005) quotes Marc Weiss's conclusion that the purpose of urban renewal (and thus displacement) is to clear land for private development of office buildings, sports arenas, hotels, trade centers, and high income luxury buildings needed by downtown merchants, banks, large corporations, newspaper publishers and realtors. Fullilove (2005) also attributes urban renewal to cities' desire to improve their tax base. While these arguments attempt to shift the focus from individuals' roles in the spatial patterning of neighborhoods, Kruse (2005) argues in his analysis of white flight that this movement from cities to the suburbs proved to be the most successful segregationist response to the demands of the civil rights movement and the legal authority of the courts.

Arguably, the shifts in population trends experienced by NPU-V residents may represent another refusal by Whites to share the same space with poor Blacks, resulting in displacement and another cycle of de facto segregation. While studies of attitudes indicate that Whites are increasingly willing to live with Blacks (Farley, Schuman et al. 1978; Farley, Steeh et al. 1994), a study of Detroit metropolitan neighborhoods suggests that there is a gap between attitude and behavior (Farley and Frey 1994). Other scholars have argued that segregation exists because of Blacks' preference to live with other Blacks (Thernstrom and Thernstrom 1997); however, studies of neighborhood diversity preferences found that although Blacks prefer to live in neighborhoods that are 50 percent White and 50 percent Black (assuming only 2 races) or a slightly greater percent Black

(Krysan and Farley 2002), Whites prefer a neighborhood that is majority White (Farley, Schuman et al. 1978; Farley, Steeh et al. 1994). When asked why, Whites name falling property values and crime as the reason why they don't want to live with Blacks (Farley, Steeh et al. 1994). Farley, Steeh and colleagues (1994) also found strong support for the hypothesis that Whites who endorsed negative stereotypes were more uncomfortable with Black neighbors, would try to move away from neighborhoods with higher proportions of Blacks, and were less willing to move into mixed areas. Participants in this study seem to be articulating phenomena that are consistent with the literature when they say "Whites of privilege are coming" and because of this, they can no longer live in NPU-V. According to participants, two key institutions working to create these dynamics are the City of Atlanta and the Atlanta Housing Authority, both managed primarily by middle class African Americans.

Disinvestment, Speculation, and Poor Neighborhood Conditions

Poor neighborhood and housing conditions were consistently named by participants in both Phase I and Phase II as factors impacting their well-being. They name mechanisms such as disinvestment and speculation as the driving forces leading to these built environment conditions. Residents described high levels of vacancy and boarded up houses, which have been demonstrated to have an impact on both physical and mental health outcomes. A study by Cohen and colleagues (2003) investigated the relationship between several predictor variables, including the percentage of housing units that were boarded up, and premature all-cause mortality as well as mortality due to specific causes (cardiovascular disease, malignant neoplasms, diabetes, homicide, suicide, asthma, pneumonia/influenza, and injuries). The researchers found that

percentage of boarded up housing units was significantly associated with premature all-cause mortality even after controlling for known socioeconomic correlates. In addition, this relationship held true for malignant neoplasms, diabetes, homicide, and suicide. The authors propose several possible explanations for some of these relationships. They suggest that the relationship to homicide is likely due to less frequent natural surveillance by residents and the greater presence of illegitimate street activities. They also suggest that premature mortality could be related to the lack of access to healthy foods and opportunities to exercise in areas marked by physical deterioration, although one study found that residents of impoverished areas walk more not less (Ross and Mirowsky 2001).

Although participants in this study did not name physical health outcomes, it is important to note the environment's impact on physical health because residents of NPU-V may also be experiencing disparate physical health outcomes as a result of living in a poor built environment. In a study by Cohen, Spear, and colleagues (2000), a relationship was found to exist between neighborhood deterioration and gonorrhea. Neighborhood deterioration was defined using a broken windows index. "Broken windows" is a term borrowed from a theory of crime that suggests the presence of minor forms of disorder (like a broken window) in a community contributes to more serious offenses (Wilson and Kelling 1982). The broken windows index was based on the sum of the percentage of homes with major structural damage, minor structural damage, or cosmetic damage; the percentage of streets with trash, abandoned cars, or graffiti; and the number of physical problems and building code violations in public high schools. The broken windows index showed a much stronger relationship with gonorrhea rates than

poverty (measured by a combination of income, education, and unemployment at the block group level), suggesting that this traditional measure of socioeconomic status did not provide as robust an explanation for gonorrhea as neighborhood deterioration.

Another study of the relationship between the built environment and a physical health outcome, diabetes, found mixed results (Schootman, Andresen et al. 2007). Features of the external built environment (housing conditions, noise level, air quality, street and road quality, and yard and sidewalk quality) were not found to be associated with diabetes incidence; however, features of the internal built environment were. These included cleanliness inside the building, physical condition inside the building, conditions of furnishings inside the building, condition of the outside of the building, and overall condition of the dwelling. None of the anticipated mediating factors (health behavior, psychosocial factors, health status, access to medical care, and demographic factors such as income, education, and employment) were found to be responsible for the association.

Given that participants named mental health as an important health outcome and apathy as an important factor in the life of the neighborhood, the built environment in NPU-V may also be contributing to mental health problems. A study of New York City residents by Galea, Ahern, and colleagues (2005) found that persons living in neighborhoods characterized by poorer features of the built environment were 29%-58% more likely to report past six month depression and 36%-64% more likely to report lifetime depression than persons living in neighborhoods characterized by a better built environment. The features that were significantly related to depression were percentage of housing units with non-functioning kitchen facilities, heat breakdowns in winter, and large areas of peeling plaster or paint; the percentage of buildings in deteriorating

condition; and the number of structural fires in the neighborhood. The relationship between depression and the built environment has been found to be consistent even after controlling for individual characteristics (Weich, Blanchard et al. 2002).

Displacement and Broken Social Ties

Fullilove (1996) argues that the sense of belonging that is necessary for psychological well-being depends on strong, well-developed relationships with nurturing places. She describes these places in three ways. First, human survival depends upon having a location that is good enough to support life (e.g., ready, equitable access to food, water, and shelter) and people in their search for meaning. Second, place can be understood as standing for human interactions in a given location. Third, place represents the nodes of a person's life biography. Therefore, participants' earlier suggestion that place has significance beyond representing a physical location is consistent with Fullilove's argument.

Fullilove (1996) then describes three psychological processes that drive the sense of belonging to a place—familiarity, attachment, and identity. Familiarity describes the knowledge that people accumulate about the lay of the land. This familiarity is a source of ease and comfort, while an unfamiliar environment evokes "fight or flight" responses. Attachment to place, like attachment to persons, can be conceptualized as a series of emotions and behaviors that modulate distance from and maintain contact with the object of attachment, which provides protection and satisfaction. Sadness and longing are common when this attachment is lost. The term given to this loss is nostalgia, which could be symptomatic of major depression. Place can also be conceptualized as a core element in identity formation. Alienation results when a person either does not have a

place or knows that his or her place is not held in esteem by others. Residents of NPU-V may be experiencing disruption to these three psychological processes—familiarity, attachment, and identity—as a result of displacement.

The participants in this study express these psychological processes when they talk about their sense of loss as a result of the demolition of familiar places and the displacement of relatives and friends from the neighborhood. They reminisce about childhood memories and talk about feelings of nostalgia, which according to Fullilove (1996), could be symptomatic of depression. In addition, participants talk about the shame that they feel knowing that their neighborhood is viewed poorly by others.

There are several studies that have looked at the impact of displacement on health and mental health outcomes; however, most studies have been conducted in the context of war and natural disasters (MMWR 1991; Almedom, Mohammed et al. 2005; Bolton, Bass et al. 2007; de Jong, van der Kam et al. 2007). In her book *Root Shock: How Tearing up City Neighborhoods Hurts America, and what we can do About It*, Mindy Fullilove (2005) describes the negative impact of displacement as a result of "urban renewal," a type of trauma that has received little attention in the public health literature. She terms the reaction to this trauma "root shock" and draws parallels to the physiological shock experienced by a person as a result of a physical injury.

Therefore, community health and mental health are compromised twice—when residents are exposed to poor living conditions after years of disinvestment and speculation and again when they are displaced due to "urban renewal" or "redevelopment." When participants were asked during the member checking meeting to create a label for this combination of disinvestment, speculation, and displacement, they

used the term “powerless transitions,” a term that encapsulates the changes that are taking place in the community over which participants feel they have little or no control.

Strategies to Mitigate, Resist, and Undo the Impact of Fundamental Causes

African Americans in this neighborhood describe several strategies that they use to mitigate, resist, and undo (Geronimus 2000) the effects of the above factors on their well-being. They describe help-seeking behavior; attempts to organize; and actions that resist as well as those that cooperate. They also expend a great deal of energy trying to reconcile what’s happening in their environment with their and others’ roles in the causation.

Geronimus (2000) used the terms “mitigate,” “resist,” and “undo” to describe the actions taken by African Americans to manage social and economic adversity. The action she describes most is the development of social networks and a set of autonomous institutions that help low-income Blacks to manage the many social forces that work to their demise. Although these social networks do exist in NPU-V, the disruptiveness of displacement may have severely impacted these networks. According to Geronimus (2000), the same forces that contribute to the ghettoization of poor African Americans may have also dealt a series of hard blows to critical social network systems, leaving the networks with fewer resources to meet the demands of its members. What Geronimus (2000) and participants describe as lacking in communities may be best described by “ubuntu.” Bishop Desmond Tutu defines “ubuntu,” a word found in many African languages to describe community, as what it means to be truly human. Tutu (1994) states that ubuntu refers to:

"gentleness, compassion, hospitality, openness to others, vulnerability, availability to others, and to know that you are bound up with them in the bundle of life, for each person is only a person through other persons" (125).

Participants described many aspects of community well-being such as connectedness, relationships, and concern for each other that mirror "ubuntu." However, because of the many "powerless transitions" taking place in the community (disinvestment, speculation, and displacement), the ability to practice ubuntu is compromised.

Summary of Explanatory Model

In summary, one of the two fundamental causes named in this model is the mobility of Whites, which is historically and currently tied very closely to policies that support or influence the mobility of White Americans. The word "support" suggests that Whites' desire to live in exclusively White neighborhoods is supported at the policy level, while the word "influence" suggests that other drivers such as business interests and real estate and development interests actually shape Whites' mobility. Either way, participants recognize this mobility as a major factor impacting community well-being. The second fundamental cause named in this model is indifference, a phenomenon that describes both White and Black middle class Americans' sentiment toward low-income African Americans. For White Americans, this indifference is institutionalized in dominant race and class ideologies represented by the outermost sphere. For middle class Blacks, this indifference is also institutionalized locally through city government and the Atlanta Housing Authority, two institutions that are primarily managed by Black middle class Americans. These institutions (along with others such as banking and real estate

interests which are not primarily managed by African Americans) develop and support policies (including the differential enforcement of those policies) that have resulted in significant levels of disinvestment, speculation, and displacement in NPU-V. This trio of mechanisms serves to create poor neighborhood and housing conditions as well as broken social ties, which leads to poor community well-being and poor mental health outcomes for NPU-V and its residents. Both the fundamental causes and dynamics that they create are represented by the large arrows pointing inward toward the community at the center. Residents of NPU-V try to mitigate these forces (symbolized by the four small arrows radiating outward from the center) through the use of various strategies, which at times are successful but not enough to prevent the negative impact on the community's well-being and the mental health of its residents.

Psychosocial stress is not specifically named in the model although many of the factors that are named have been conceptualized in terms of psychosocial stress. For example, the indifference that participants name may be related to the concept of racism, which has been long thought to be an important predictor of low SES and exposure to other environmental and social stressors (Clark, Anderson et al. 1999). Similarly, the housing and neighborhood conditions that residents named have also been framed as psychosocial stressors (Israel, Schulz et al. 2006).

Although many of the factors named in the model are related to segregation, which has been offered in the literature as a fundamental cause (Williams and Collins 2001; Schulz, Williams et al. 2002), segregation is not explicitly named in this model. Participants did not name this phenomenon except in the few circumstances where participants suggest that the presence of Whites in the neighborhood could improve the

quality of life in the community. It is unknown from this study whether residents would still prefer an integrated neighborhood if the living conditions were desirable.

Strengths and Limitations

Eliminating health disparities has become a major research and policy goal over the past two decades, but research and policy initiatives tend to acknowledge "fundamental causes" of disease that disproportionately affect poor minority populations yet still intervene at the risk factor level. In this dissertation study, community-based participatory research with African-American residents in NPU-V has generated formative research designed to move the field closer to designing a research, practice, and policy agenda rooted in fundamental causes and the lived experiences of those facing disparate health outcomes.

One of the strengths of this study is the use of Photovoice to understand priority health concerns and fundamental causes from residents' perspectives. Use of cameras helped to generate vivid images and stories about the lived experiences of residents of NPU-V in a way that traditional focus groups do not. An additional strength of this study is the collaboration with partners living and working in the community to design and implement the study. The success of this study can be attributed to the strengths and contributions of each partner. For example, when participants in Phase II were experiencing difficulty returning their cameras, it was the community organizer at TCWFI who led our efforts to connect with residents through door-to-door outreach. Other partner contributions included planning, logistical, and fiscal support (Georgia

State University Institute of Public Health) and staff and data support (Annie E. Casey Foundation Atlanta Civic Site).

Other study strengths relate to participant involvement. Based on their demographic profile, participants in this study are some of the most marginalized residents in the city of Atlanta, yet we were able to develop a relationship that allowed us to explore the issues raised in this study. Fifteen of the 20 participants returned for the member checking meeting that was scheduled for each phase. In these meetings, participants confirmed the themes and relationships between themes that were identified. They also provided insights about the labeling of one of the central concepts of the explanatory model—powerless transitions, a term used to describe the combination of long term disinvestment, speculation, and displacement.

One unknown limitation of using the Photovoice process to understand perceptions of health is that the camera may invite a more built environment analysis because it may be easier to take pictures of a concrete object such as an abandoned house than it is to capture a more abstract condition such as hypertension. However, photographs of the built environment still enabled participants to explore more abstract concepts such as apathy, mental health, and indifference.

Another limitation of the study is the use of convenience sampling. The participants in this sample could produce different results than a representative community sample because they are already engaged in community processes through activity in the ACHT project as well as Center for Working Families programs. An attempt was made, through chain referral selection, to involve residents who were not participating in these or other community activities. There are also very few participants

because of the nature of Photovoice (i.e., small group dialogues); therefore, participants may not be representative of the approximately 15,000 residents of NPU-V.

On average, the persons in this sample live below the poverty line based on the US Department of Health and Human Services (2007) poverty guidelines. According to *Neighborhoods Count: A Look at NPU-V in 2004* (2004), which was based on the 2000 Census, approximately 43% of NPU-V families live below the poverty line. Therefore, persons who are very poor were overrepresented in this sample. The sample did not include residents of Summerhill, a more racially diverse and higher income neighborhood in NPU-V. Summerhill residents' perceptions may be markedly different from the participants in this study. Women were also overrepresented in this sample. Women make up 54% of the NPU-V population; however, they accounted for 77% and 86% of the two study samples. The educational level and unemployment rate for Phase II participants is consistent with the neighborhood average, while Phase I participants had higher levels of education and employment, although the latter may result from the fact that six of the 13 Phase I participants were employed by the ACHT partnership.

Another limitation of the study was the size of the Phase I dialogue sessions. There were 13 participants in these sessions, and conversations were limited due to time constraints. During some dialogue sessions, participants were only able to share one photograph with the group instead of the intended two photographs, which may have allowed for a broader set of themes for analysis and discussion. We had additional participants because two CHWs each invited one of their own young adult children (15 and 17 years old) to participate. Although this was not the ideal situation, we did not want to exclude them when they arrived on the day of orientation and training. However, we

placed these two young adults out of the line of sight of their parents during dialogue sessions to reduce the potential for the power dynamic between parent and child to influence the child's responses.

An additional study limitation relates to the initial framing question used for Phase I and Phase II. While Phase I participants were asked to document "health" to answer the study's first research question, Phase II participants were asked to document "life at McDaniel-Glenn" because of AECF/ACS's interest in housing and relocation. Therefore, the ability to make comparisons across these two groups, particularly in the naming of health concerns, is limited. However, because of the similarity in themes related to institutional impact on living conditions, I was able to develop one explanatory model based on both sets of data.

One of the key aspects of developing a grounded theory is theoretical sampling, which involves data gathering driven by concepts derived from the evolving theory (Strauss and Corbin 1990). Data gathering typically occurs throughout the process as themes and important ideas emerge. One of the limitations of this study is that the researcher did not engage in the process of theoretical sampling. All data were coded after the conclusion of the dialogue sessions, and therefore, questions that were raised during the coding process could not be fully expanded upon and thus important factors may be missing from the explanatory model. One potential benefit of the way in which this study unfolded is that participants, through their own theme-building at the end of each dialogue session, determined the topics for further exploration.

Validity

Threats to validity in qualitative research include changes in the people and the neighborhood over time; changes in what participants say because the researcher is present; some components of the population may be excluded; and researchers can report false or premature conclusions (Schensul, Schensul et al. 1999). This study attempts to control for these threats (respectively) by researcher presence in the community over time and in varying contexts; involving trusted co-facilitators in the process and conducting all dialogue sessions in which data were collected in a familiar setting; collecting information on who the participants are and speculating who might be omitted; and including a member checking meeting prior to finalizing results.

Threats to external validity include using and describing concepts or instruments inappropriate for use with another group because they were developed for the current group and failing to document unique historical experiences of the group (Schensul, Schensul et al. 1999). To control for these threats, the study (respectively) uses a research methodology that has been used in various settings and populations and includes clear documentation of unique experiences in NPU-V.

Implications for Public Health Research

Study the Impact of Displacement on Health and Mental Health. Although displacement has been recognized as an important factor contributing to poor health and mental health outcomes, research in this area has primarily focused on displacement as a result of war or natural disasters. A review of the literature finds very few research articles on the health and mental health impact of displacement due to "urban renewal."

In fact, psychiatrist Dr. Mindy Fullilove appears to be the only researcher linking this type of displacement to health even though displacement has been impacting low-income African Americans since the early to mid twentieth century. Other researchers in the areas of urban planning and economics are studying the impact of displacement on various outcomes of interest, such as socioeconomic status (Keating 2000; Boston 2005); however, public health seems to be missing from the dialogue, possibly due to a narrow focus on physical health. Research in this area should focus not only on those who are displaced but also those who remain in neighborhoods undergoing gentrification. This research implication is timely and necessary given the rise and probable continuation of gentrification patterns in America's urban cores into the foreseeable future.

Design and Test Interventions Aimed at Altering Normative Perceptions. Another important implication of this study's findings for public health research is the design of interventions that are aimed at altering normative perceptions of low-income African Americans to diminish the level of institutional and individual indifference that impinges on their quality of life and other social and physical health outcomes. Possible interventions include developing messages that challenge stereotypes of African Americans and testing through neuroscience their impact on culturally learned responses to images of African Americans. Once proven to be effective, the technology is currently available to deliver these messages to the American public through various media outlets. Research in this area should focus on altering the perceptions of White and Black middle class Americans and to a lesser extent, moderate and low-income African Americans. While several studies have been conducted on the perceptions that White Americans have toward Blacks, there are limited studies on the perceptions that middle class Blacks have

of poor Blacks. Notwithstanding, studies of and intervention research aimed at middle class Blacks cannot be divorced from research about Whites' perceptions. According to participants in this study, middle class Blacks may be responding to the needs and preferences of Whites; therefore, it will be important to understand how Whites' and middle class Blacks' perceptions of poor Blacks shape and reinforce each other. Other intervention strategies for addressing normative perceptions include Undoing Racism, a series of workshops that helps individuals, communities, organizations and institutions to analyze and deconstruct the causes of racism (People's Institute for Survival and Beyond 2008).

Conduct Research that Explicitly Examines the Interface between Structures, Individual Attitudes and Perceptions, and Health. The above implication focuses on individual attitudes and perceptions; however, according to the theory of structuration, individuals' actions cannot be divorced from the structures that individuals draw upon to create and recreate social systems. If research focuses on individual perceptions without attention to structures (and vice-versa), then we will continue to observe the disparities in health that limit the life circumstances of minority group members. Research in this area should focus on model-building that explicates the relationships between structures, individual perceptions, and health. In the example of White American mobility, it might be important to understand how White Americans draw upon existing structures to perpetuate segregated neighborhoods, which in turn contributes to the poor health outcomes of African Americans. This understanding should then be followed by the difficult task of developing and testing interventions that educate and empower

individuals and groups to disrupt these structures. According to Giddens (1984), structures are disrupted when people ignore, replace, or reproduce them differently.

Conduct Research on Mental Health at the Local Level. Participants in this study talk about a general sense of apathy felt by people living inside NPU-V and describe feelings of hopelessness, defeat, and not caring. These feelings seem to characterize some of the symptoms of depression such as negative personal outlook, diminished interest, and anergia. However, the perceived widespread prevalence of apathy in NPU-V is not consistent with national surveys of depression. Survey research on the mental health of African Americans reveals lower rates of lifetime prevalence of major depressive disorder (MDD) for Blacks than Whites (Williams, Gonzalez et al. 2007) and similar rates of MDD for both Blacks and Whites during the 12 months prior to the interview, although MDD was found to be more chronic for Blacks than Whites. One implication of this study is to better understand if this apathy described by residents is characteristic of depression.

In the example of mortality and life expectancy studies, greater disparities were found when researchers analyzed these data at the local level across neighborhoods that are geographically close yet racially and socioeconomically different (Geronimus, Bound et al. 2001). Therefore, research on mental health at the local level may reveal undetected mental health disparities. In a series of ACHT listening sessions with approximately 70 NPU-V adult residents, in response to the question "How many days in the past 30 days was your mental health not good?" 26% of participants stated that their mental health was not good 15-31 days. This statistic was part of the impetus for NPU-V residents' choosing mental health (i.e., depression and stress) as the outcome of interest

for intervention by the ACHT partnership even though national studies would indicate that depressive disorders are not as prevalent among African Americans.

Conduct More CBPR, Grounded Theory, and Photovoice Studies on Racial/Ethnic Health Disparities. The racial/ethnic health disparities research arena could benefit from more studies grounded in the language, perspectives, and lived experiences of low-income African Americans. Although these studies have small sample sizes and limited external validity, it may be necessary to understand and address racial/ethnic disparities at the local level for some issues, while other issues may surface (such as displacement) that have far reaching implications because they affect African American populations all across the country. Used appropriately, the CBPR approach and the Photovoice methodology are ways of conducting research that empower residents to 1) uncover fundamental causes, mechanisms, and their outcomes and 2) develop strategies to address them.

Implications for Public Health Practice and Policy

Further Integrate Public Health and Urban Planning. In an article about the histories of urban planning and public health, Corburn (2007) argues that practitioners in the these two fields have much to gain by working more closely together. According to Corburn (2007), the current attempts to bring these fields together have focused too much on designing communities that promote physical activity, which he argues does not attend to issues of political power, governance, institutional design, and epistemology that can influence whether interventions address the root causes of poor health such as poverty and discrimination. Although he criticizes both fields for their 19th century

solutions to urban problems which focused on removal of both waste and sick people, he argues that both fields can work together through processes such as health impact assessments. A health impact assessment is commonly 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 (Dannenberg, Bhatia et al. 2006). Through health impact assessments, proposals that will significantly alter the built and social environment can be assessed for their potential health impact before projects are launched.

Implement Moratoria on Federally Funded Displacement. In the face of continued debate about the impact of displacement on outcomes for low-income families, a closer collaboration between the fields of public health and urban planning using processes such as health impact assessments is warranted. In the meantime, the precautionary principle should apply. The precautionary principle states that if an action might cause severe or irreversible harm, in the absence of scientific evidence that harm would not ensue, the burden of proof falls on those who would advocate taking action (O'riordan and Camerson 1994). In this case, the precautionary principle would suggest a moratorium on further displacement of public housing residents as an immediate practice and policy implication of this research. The research on displacement and health is poorly understood, and the little research that does exist stirs significant public controversy. At the same time, there is a dire need for investments in public housing to eliminate threats to health in the built environment.

Invest in Infrastructure in Low-Income Neighborhoods. Many of the living conditions in NPU-V, such as poor infrastructure and housing quality, are thought to be

related to segregation (Williams and Collins 2001). Although there is evidence that living in segregated neighborhoods poorly impacts health for African Americans (Williams and Collins 2001; Schulz, Williams et al. 2002), poor Black neighborhoods continue to languish as Whites' preferences to live in nearly all White neighborhoods remain relatively stable and are supported by zoning, real estate, and banking policies. Therefore, significant investments in infrastructure (i.e., streets, roads, dilapidated housing) should be a priority for local, state, and federal policymakers. It is clear from the participant's own voices as well as the supporting literature, that these built environment factors are an important aspect of health that is less well described in the health disparities literature.

Support Local Public Policy Campaigns. The third goal of Photovoice (following photo documentation and critical dialogue) is to influence policymakers such that they enact more healthful public policy. One practice and policy implication of this study is the support of communities like NPU-V in the creation of local public policy campaigns regarding issues of neighborhood deterioration, gentrification, and displacement. In the case of NPU-V, residents and the collaborating partners began meeting in January 2007 to develop an initiative to change local policy based on the NPU-V Photovoice process. This initiative came to be known as the Dirty Truth Campaign. A description of the Dirty Truth Campaign is included in Appendix C.

CHAPTER 6

Concluding Remarks

Initially, my role in the ACHT partnership was to utilize the Photovoice process to conduct a needs assessment in NPU-V. Because of my lack of familiarity with the neighborhood, I was interested in using Photovoice with residents to explore any topic they wished. I did not know what would be uncovered in the process. The topic of trash was raised several times, even to the point where one participant said he was sick of talking about it. At first glance, trash did not seem to me to have many far reaching implications. The turning point for me was the dialogue session in which participants stated that the “numbers don’t work for us.”

As discussed in chapter four, I was unable to fully understand the meaning of this statement without additional clarification from one participant. Her narrative (see page 78) brought into focus the many years of neighborhood and housing disinvestment experienced by residents of NPU-V. I would have never known without the help of study participants, how connected trash is to the structural issues of disinvestment, speculative development, displacement, poor neighborhood and housing conditions, and racial and class attitudes and perceptions. “The Numbers Don’t Work for Us” therefore became the title of this dissertation because it expresses so many aspects of these issues, as described below.

- Residents stated that the phone numbers that they have used to call on the City of Atlanta and the Atlanta Housing Authority don't work, in that they receive little or no response.
- The large numbers of vacant properties as a result of speculative development doesn't work to create safe and viable communities.
- The numbers of people who have been displaced from the community doesn't work to sustain relationships and connectedness essential for safeguarding already burdened social networks.
- The statistics or numbers describing health disparities don't work for African American communities where people are experiencing the negative effects of these disparities, including elevated levels of morbidity and mortality.

Fifty years after Jim Crow's official end, overt mechanisms of segregation have morphed into processes that covertly discriminate against poor African Americans. If we are to witness an end to health disparities, it will not come through attempts to change the individual behavioral choices of people experiencing disparate health outcomes. Individual behavior is just one piece of this puzzle, and I argue that it is a very small piece when we consider the many fundamental causes that need to be addressed to allow poor Black Americans to even have the opportunity to attend to their health.

Link and Phelan (1995) popularized the term "fundamental causes" and gave it some parameters. One parameter is that a fundamental cause involves access to resources that help individuals avoid diseases and their negative consequences. Although a critical component, the parameter of individual socio-economic well-being is a limited way to

conceptualize the factors that contribute to poor health outcomes for African Americans. I concur with Geronimus and Thompson (2004) who stated that:

> *"The relatively longer, healthier lives of Whites are conditioned not only on greater access to material resources, but also on the psychic benefits of having their values honored in public discourse and institutional structures and timetables. Explanations for racial health inequality must encompass the impact of pervasive insults to the personal and collective integrity of African Americans." (254)*

Geronimus and Thompson (2004) argue that social epidemiologists and policy advocates pay more attention to economic welfare than to affective ties and social identity. They assert that this reflects the large degree to which economistic assumptions have permeated cultural discourse. In this study, participants support the importance of these social ties and identity in their discussion of lessening community well-being. Many participants did speak to the economic struggles that they face, but primarily they name community well-being and mental health and the many systems that impinge upon these two outcomes. Participants seem to come closer than the research and policy community has in naming health in terms of the World Health Organization's definition of complete physical, mental, and social well-being.

One of the more troubling issues raised by this study is the suggestion in the implications section that part of the intervention research agenda be devoted to altering normative perceptions of low-income African Americans. As a structuralist who has long thought that individual acts of overt racism have been replaced by institutional racism, it is difficult to imagine a research agenda that includes attention to individual attitudes and perceptions. However, institutions are created and supported by individuals; therefore, their attitudes are an important part of the overall picture.

I recall when my family moved onto an all White street in Stone Mountain, Georgia in 1994. Within months, our neighbor across the street had moved away. Within just a few years, the entire street's racial composition had changed such that only one White family remained. These families had moved to sprawling suburbs even further away from the city center supported by millions of dollars in investments in housing, highways, and retail. My parents' neighborhood is still thriving, but will years of inner city disinvestment now depart for the suburbs as the city becomes the hub of investment for banks and developers? What then will become of the suburbs as poor inner city residents are displaced there with decreasing investments?

The explanatory model that I developed with help from participants attempts to explicate how institutionalized attitudes and beliefs can translate into various dynamics (e.g., mobility, disinvestment, speculation, and displacement) that ultimately serve to create unhealthy built and social environments for poor African Americans. While socioeconomic arguments are robust and explain much of the racial/ethnic disparities in health, the factors uncovered in this study deserve further exploration if we are to eliminate racial/ethnic disparities in health. The explanatory model presented in this study attempts to create additional directions for the field of public health that focuses our attention on the intersection of the urban planning process and public health. The model can be used as a guide for communities, researchers, and practitioners to design interventions at the practice and policy levels that support communities in achieving physical, mental, and social well-being.

APPENDIX A

Accountable Communities: Healthy Together Specific Aims

The specific aims for this research effort are to:

I. Engage community residents through community health forums designed to (1) strengthen community involvement and participation, (2) publicly assess relevant health related information including existing social, economic, demographic and health data, graphic depictions from Photovoice, and documented concerns expressed by community residents, (3) based on partnership consensus, identify, prioritize, and select for intervention the specific health disparities (and their relevant determinants), and (4) collectively develop a comprehensive intervention strategy designed to mitigate the health disparities identified.

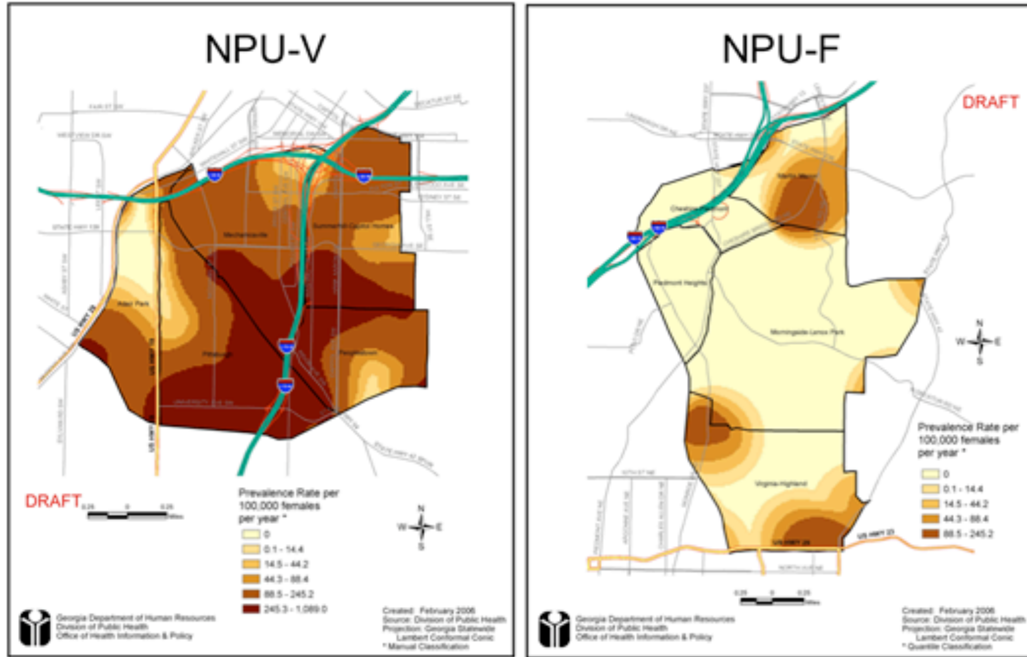
II. Train residents of NPU-V as community health workers (CHWs) in a range of community health promotion skills, including Photovoice, which will be used to complement existing community specific data gathered by residents.

III. Establish and implement a system to enable the ongoing monitoring and evaluation of the intervention strategy and the overall CBPR process. A critical additional assessment feature will include the measurement of extant levels of organizational social capital throughout the project to detect the effects of planned efforts to strengthen social capital.

IV. In parallel with the specific proximal health disparity intervention, undertake and document a longer-range strategy to address distal social and economic issues, wherein community residents assume the leadership for proposing specific actions to promote community transformation. Based on community input, these might include: (1) enhancing employment opportunities, (2) improving housing through neighborhood renewal without tax increases on current residents, and (3) promoting economic development.

APPENDIX B

Type II Diabetes Prevalence (Females) Comparison GIS Map: NPU-V and NPU-F



APPENDIX C

Dirty Truth Campaign Description

After all Photovoice dialogue sessions were completed, participants presented their pictures and stories to the NPU-V Photovoice Guidance Committee in October 2006. The Guidance Committee was created to serve as a bridge between residents and the larger policy and media community. There are 20 Guidance Committee members who represent foundations, media, community-based organizations, and the policy community. The Guidance Committee recommended that participants and collaborators determine the magnitude of the problem to assist in developing a policy change agenda.

In order to determine the magnitude of the built environment challenge, a request was submitted to the Neighborhood Data Advisory Group (NDAG) in November 2006. NDAG is a resident-based data resource in the community that had previously developed the book Neighborhoods Count: A Look at NPU-V in 2004 in partnership with Annie E. Casey Foundation Atlanta Civic Site (AECF/ACS). Modeling after Mindy Fullilove's Community Burn Index (Fullilove 2005) and inspired by her visit in October 2006, neighborhood captains and their teams surveyed each plot in all NPU-V neighborhoods using maps and codes developed by AECF/ACS. These data were collected between November 2006 and January 2007. The key finding from the survey was the presence of 1296 vacant or unoccupied properties in NPU-V, representing 42% of all properties in the neighborhood.

Photovoice participants, other NPU-V residents, ACHT community health workers, the study PI, the Community Organizer, and Master of Public Health students

formed a core team that began meeting in January 2007 to develop an initiative to change local policy based on the NPU-V Photovoice process. This initiative came to be known as the Dirty Truth Campaign. Thematically, the Dirty Truth Campaign includes two major foci – Vacant Properties and Loss of Community. The Vacant Properties arm launched first and included the following components.

Assessments. The primary assessment involved the determination of the magnitude of the vacant property challenge. As noted, the data from NDAG indicated that there were 1296 vacant properties, representing 42% of the properties in the neighborhood. The Campaign also conducted an assessment of existing policies that, if enforced, could alleviate the presence of blighted properties through code enforcement. In addition, the National Vacant Properties Campaign (NVPC), which represents a partnership between Smart Growth America, Local Initiatives Support Corporation, and The Metropolitan Institute at Virginia Tech was contracted to provide technical assistance to the Campaign, which included assessments of the policy environment and recommendations for activation of policies in the area of code enforcement.

Message Development and Dissemination. The initial messages that were developed were intended to educate community residents and policymakers about the magnitude of the problem and the relationship to health and mental health as well as crime and other quality of life issues. The first dissemination efforts occurred during the weeks leading up Earth Day (April 2007) and included presentations at NPU-V meetings involving enlarged photographs from the Photovoice process, testimonials, and dialogue about the 1296 vacant properties in the neighborhood. During this time period, www.dirtytruth.org was launched to target policymakers. Messages were also printed on

postcards, water bottles, and flyers and disseminated at community meetings, through door-to-door efforts, and at major events, including Earth Day. Photovoice participants' photographs have been accepted as part of an exhibit entitled Urban Interventions that explores the impact of development in Atlanta. The photographs will be on display from January – March 2008; a special dialogue will be hosted with local policymakers in February 2008. The exhibit will be followed by a traveling exhibit. The site of the first traveling exhibit will be the Juvenile Justice Center located in NPU-V. This exhibit will feature photographs taken by middle school students in a mini Photovoice project that was hosted by the Community Organizer at The Center for Working Families, Inc, TCWFI. These photographs are intended to inform the juvenile justice community (e.g., judges, counselors, etc.) about the impact of the built environment on the mental health of the neighborhood's youth.

Policymaker Outreach. As part of the Earth Day dissemination efforts, representatives from community-based organizations, policymakers, Photovoice participants, and other community members were invited by the Dirty Truth core team to participate in a bus tour of the NPU-V community. A half-hour presentation preceded the 1-hour bus tour and included a list of recommendations, including weekly street cleaning and abatement of properties with serious code enforcement violations. Of the 52 bus tour participants, 26 were policymakers, including city council members and representatives from the Atlanta Housing Authority, the Solicitor's office, and the Fulton County Health Department. Continued policymaker outreach included one-on-one meetings with policymakers such as the Director of the Bureau of Code Compliance and the Solicitor. Of the Dirty 100 properties identified through community mobilization

efforts, 20 were selected for initial advocacy within the Bureau of Code Compliance with the goal of abatement within a 30-day period.

To further analyze and improve the code enforcement process (e.g., high staff turnover, lack of electronic tracking systems), we have involved the Bureau of Code Compliance and other city officials in conversations with the National Vacant Properties Campaign (NVPC), which resulted in a significant financial investment by the City of Atlanta in the technical assistance that is being provided by NVPC. This technical assistance is designed to streamline and enhance the local code enforcement processes to address vacant properties; assist nonprofits in acquiring and reusing vacant properties more quickly and efficiently; identify policy and program changes at the local and state levels; and gather relevant model practices from other cities.

Community Mobilization. TCWFI has taken leadership on the community mobilization activities of the Campaign. On Earth Day, approximately 40 volunteers from across the community participated in door to door efforts to educate residents about the vacant property challenge. These volunteers documented 100 priority properties and interviewed residents who lived near these properties to understand their perceptions of the properties and its impact on health, mental health, and crime. Volunteers distributed 400 bottles of water, which had been inscribed with information about the vacant property challenge and the website address for the Campaign. They also collected the first 300 signatures for a petition calling for abatement of nuisance properties in NPU-V.

Since Earth Day, the Campaign has mapped the 100 priority properties and created target zones around schools and recreation centers for its mobilization efforts. The current community mobilization activities include door to door outreach within a

target zone followed by a living room chat one week later to discuss the vacant property challenge, a process that is repeated within a target zone until there is increasing momentum around 1-3 neighborhood based projects. For example, the Peoplestown community defined "community reconnection" as an issue that is related to its ability to address the vacant property challenge. Community members then mobilized around "community reconnection" through the hosting of two block parties. Living room chats have since taken place in Summerhill and Pittsburgh.

Partnership Building. The We Care campaign is a pledge program that allows existing community-based organizations to pledge their support for Dirty Truth Campaign activities and demonstrate to community residents that they do care. This campaign was based on the fact that "no one cares" was the most repeated statement in the Photovoice dialogues. Thirteen organizations have submitted pledge sheets indicating their participation. Organizations have pledged to participate in activities such as organizing mailings to policymakers, providing meeting space, and participating in community outreach.

Media Advocacy. Media advocacy is the strategic use of news media to advance a social or public policy initiative (Holder and Treno 1997). The Campaign's media advocacy efforts are intended to influence public perception of the issue that can in turn influence policymakers. Initial strategies for engaging the media involved press releases coinciding with the Campaign's Earth Day activities. Through outreach to the media community, a local television station participated in the policymaker bus tour and aired a segment during the evening and morning news. A Photovoice participant was the spokesperson for the Campaign and described the nature of the vacant property challenge

and the Campaign's recommendations for addressing the problem. Since this segment aired in April 2007, there have been 11 television news segments about the Campaign's activities.

Results. Since the launch of the Campaign, the Bureau of Code Compliance has created a special task force to address open and vacant properties, and in November 2007, there were five demolitions of chronically dilapidated houses in NPU-V. Additional research is needed to determine with more certainty whether these activities resulted from the Campaign's activities. A survey of policymakers has been developed to understand the Campaign's impact on policymakers' perceptions of the Campaign and the vacant property challenge in NPU-V as well as any actions taken to support the work of the Campaign.

At the Campaign's first strategic planning meeting in October 2007, it was decided that the Dirty Truth Campaign would begin a process toward full community ownership. Georgia State University and the Annie E. Casey Foundation Atlanta Civic Site would still be supportive as collaborating organizations, but the Campaign would be independently managed by community residents. One important result of this policy advocacy effort has been the development of an entity that will be community owned and managed.

APPENDIX D

SHOWeD Questionnaire

1. Your name: ____
2. Date: ________________ Picture number: __________________
3. What is a potential title for this picture?
4. What do you See here?
5. What is really Happening here?
6. How does this relate to Our lives?
7. Why does this situation, concern, or strength exist?
8. What can we Do about it?

APPENDIX E

Dialogue Session Tracking Form

Facilitator name(s):

Meeting location and date:

Start and end times:

Framing Question(s):

Participant Name	Photo Number	Photo Title	✓ If Selected for Later Discussion
1.			
2.			
3.			
4.			
5.			
6.			
7.			

1. What issues / topics were discussed by the group?

2. What emergent themes were identified?

3. What framing question(s) will be used for the next round of photos?

4. What challenges were encountered in facilitating this session?

5. What would you do differently to make the next session better?

APPENDIX F

Demographic Data Collection Form

Age:

Race:

Gender:

Household Income:

Highest Level of Education Completed:

Currently enrolled?

Employed (yes or no):

If yes, are you working as much as you want to be working?

Number of Years Living in NPU-V:

What neighborhood do you live in?

Marital Status:

Own, Rent, or Live with family member (circle one)

Number of Children:

Number of people living in household

APPENDIX G

Participant Consent Form

Georgia State University Institute of Public Health

Participant Informed Consent

Title: NPU-V Photovoice
Principal Investigator: Marshall Kreuter, PhD
Project Director: Yanique Redwood, MPH
Sponsor: National Center for Minority Health and Health Disparities

Background Information

Georgia State University is conducting a project to better understand strengths and challenges in NPU-V. The name of this project is NPU-V Photovoice. The project involves people taking pictures and talking about them. The project also involves showing pictures to policymakers.

The NPU-V Photovoice Project

You are invited to participate in this research study called NPU-V Photovoice. If you decide to participate, you and 6-9 other residents will be given cameras. You will take pictures of people, places and things that are important to you.

Once the film has been developed, you and the other participants will meet with the project staff to discuss your photographs. These conversations will be tape-recorded.

At the end of the project, you may volunteer to present your pictures and stories to community leaders.

The cameras and cost of all film development will be covered.

This project will last three months. There will be an orientation and 5 workshops. Each workshop will be 3 hours long. You will also spend 2 hours per week taking pictures.

You will receive a $25 stipend for each session that you attend. The payment schedule is:

- $50 gift check - end of workshop1
- $50 gift check - end of workshop 3
- $50 gift check - end of workshop 5

Risks

A possible risk of participating is that you could be harmed while taking pictures. Every precaution will be taken to minimize your risk. No picture is worth taking if it puts you at risk or causes ill will. You will receive training on:

- safety rules while in public
- acting responsibly towards the public
- respecting the rights and privacy of others

Prior to taking pictures of other persons, you will ask their permission and obtain signed consent.

Georgia State University and its partners cannot be held liable for any harm that you may experience while participating in this project. In the event of an emergency, call 911.

Benefits

Benefits of participating in NPU-V Photovoice are:

- you will be able to keep your camera and pictures
- you will be able to voice your concerns to community leaders
- you may experience satisfaction with helping to improve your community

Voluntary Participation and Withdrawal

Participation in research is voluntary. You have the right to refuse to be in this study. If you decide to be in the study and change your mind, you have the right to drop out at any time. Whatever you decide, you will not lose any benefits to which you are otherwise entitled. If you decide to drop out, you will still receive a $25 gift check for any session that you attend.

Confidentiality

We will keep your information private. Only project staff and research partners will handle your information. To protect your privacy, no names will be noted unless we have your written permission. Because you will discuss your pictures in a group setting, we cannot guarantee confidentiality.

Consent forms will be kept in a locked filing cabinet separate from your pictures, worksheets, and audiotapes. The audiotapes will be destroyed within three months of the final workshop.

The information from the worksheets and audiotapes will be typed and stored on a computer that is password and firewall protected.

For More Information, contact:

Call Yanique Redwood at (404) 564-6933 if you have questions about this study. You may also call Marshall Kreuter at (404) 651-2234. If you have questions or concerns about your rights as a participant in this research study, you may contact Susan Vogtner in the Office of Research Integrity at (404) 463-0674 or svogtner1@gsu.edu.

Consent

We will give you a copy of this consent form. I have read the above information and the above information has also been read to me.

I (please print name/s) ____
agree to participate in the NPU-V Photovoice Project.

____ ___________
Participant Signature Date

____ ____________
Researcher Obtaining Consent Date

APPENDIX H

Referenced Photographs

Fast Food Nation by a 31-year old female

What do you See here?
People walking downtown on Broad St; people eating at restaurants along Broad St; ambulance.

What is really Happening here?
Everyone is on the go! Fast food chains next to each other existing to support the rushed/fast paced lifestyles of the individuals who patronize them.

How does this relate to Our lives?
This relates to our lives because if we speed through life then before we know it the very things that are worth living for will be a blur.

Why does this situation, concern, or strength exist?
We have become a nation that no longer takes the time to eat and fellowship with one another like our ancestors. Eating, shopping, and entertainment have all sped up to meet the needs of the super busy consumer.

What can we Do about it?
Deprogram- slow down- dedicate a time of day where we become still – this will benefit us both mentally and physically overtime. It will ultimately strengthen our families and communities.

Danger by a 46-year old female

What do you See here?
Not a healthy store, like a alcohol place. People hang out and no groceries or vegetables are available.

What is really Happening here?
Danger. This is killing our neighborhood. Alcoholism and people hanging out.

How does this relate to Our lives?
It's killing our community. There is nothing here that's healthy for our bodies. This is just a way the store owner is making money.

Why does this situation, concern, or strength exist?
Because it's all about dollars.

What can we Do about it?
Rally together and get liquor licenses taken. Get this store closed.

New Development by a 36-year old male

What do you See here?
Construction work in progress in early stages.

What's really Happening here?
What is happening is what you don't see from the picture standpoint. It is the displacement of families and the relocation and families being moved away. You don't see that at all.

How does this relate to Our lives?
Change, schools, and breaking social ties and tradition that have been in the community for a while and is subject to change when they're moving out here and they don't have community resources where they're living at, a lack of resources.

Why does this situation, concern or strength exist?
It's reality. Change is happening simultaneously around the entire city. How can we take advantage of this situation and benefit the whole community?

What can we Do about it?
We can continue to educate, organize, assist residents for jobs in the community, with emphasis on job training.

Atlantis in Atlanta by a 46-year old female

What do you See here?
This is a picture of the former Grady Homes.

What is really Happening here?
I grew up across the street from here in Russell Apartments. I had lots of friends that lived in Grady Homes. When the apartments were torn down, I lost contact with lots of friends. I don't know where half of them went. There is a little area on this picture that looks like a bunker from the war and I remember we used to play there.

Why does this situation, concern, or strength exist?
I think this exists because of progress. It's progress for certain people and devastation for others. We're becoming disenfranchised.

What can we Do about it?
As far as disenfranchisement and displacement and shipping people out, we've just got to work as hard as we can as fast as we can to pass on as much knowledge as we can and just pray.

Love for Humanity by a 36-year old male

What do you See here?
A homeless man, but he is first a human.

What's really Happening here?
I went and got something to eat and saw this man. He said that he lost his family and he has been on the street for the past 3 years. He said that he goes to the shelters but he can only be there for a day or so and then they send him back out. He said that he gets arrested just for asking for food.

How does this relate to Our lives?
What happened to all the love in the black community? What happened to the care and concern for people who are going through certain things?

What can we Do about it?
We can't lose our touch for humanity.

The Pool by a 27-year old male

What do you See here?
Dirty.

What is really Happening here?
Nothing.

How does this relate to Our lives?
The kids don't have a place to cool off for the summer

Why does this situation, concern, or strength exist?
They don't care about the black community.

What can we Do about it?
Talk to the mayor.

I Can't See by a 26-year old female

What do you See here?
I see some cars parked along the side of the street and at the other end of the street you see a big dumpster.

What is really Happening here?
The dumpster is actually blocking the stop sign that exists right here and people are actually running the stop sign which may cause car accidents.

How does this relate to Our lives?
If the dumpster isn't removed, somebody in the community, either walking or riding, will be hurt.

Why does this situation, concern, or strength exist?
Because the developers have truly forgotten about this dumpster being here. It has been there for at least four months.

What can we Do about it?
There is an 800 number on the dumpster which I have tried calling but it gives you a 770 number to call which gives me the 800 number again. The numbers do not work.

Walk of Shame by a 15-year old female

What do you See here?
I see trash everywhere on a little pathway.

What's really Happening here?
Debris is thrown everywhere. No one has made it to clean up.

How does this relate to Our lives?
It relates to our lives because it can make many people sick.

Why does this situation, concern or strength exist?
This wasn't the first corner with trash that I saw. I saw lots. It was everywhere. It's like saying the community is just trash.

What can we Do about it?
Get groups together and/or see what's the real problem. Is trash on the street because of the community or because trash is already there and it doesn't matter?

Crackhead Haven by a 27-year old male

What do you See here?
A vacant apartment, boarded up, run down, and probably been burnt up and don't nobody care about.

What's really Happening here?
Nothing. That is space that somebody could be living in. Instead of relocating them folks from McDaniel Glenn, they could have relocated them to right there. They still in the same NPU-V. They ain't gotta go far. The children can still go to the Dunbar Parks. They would still be in the community instead of moving them out to Dekalb county, Gwinnett, and other places.

How does this relate to Our lives?
It's a bad place because it's not too far from an elementary school. One of these crackheads can get crazy and hurt one of the kids at the elementary school.

Why does this situation, concern or strength exist?
We as black community don't do enough to call and harass folks to knock down these buildings; therefore, the building is still here. And, it looks like it's been vacant for 4-5 years now.

What can we Do about it?
Call down to city hall. Or, if we have to, get a stick of dynamite and blow it up ourselves. We just need to do something about it because it's not too far from the elementary school. Somebody in the government (Shirley Franklin, city council) needs to look at this, but their main focus is Buckhead and Virginia Highlands. They never come down here to us.

Emptiness by a 47-year old female

What do you See here?
It's a gated fence that used to be Mechanicsville.

What is really Happening here?
All of those things that were there - family, community leaders that helped us during our struggle, those that are familiar with it and helped us get from point A to point B. We don't see that anymore. The thing is like Las Vegas - nothing but a dry desert.

How does this relate to Our lives?
It relates to our lives today because there have been family, kids, as well as a love for a community, that's just not been here no more. It's not here no more.

Why does this situation, concern, or strength exist?
People that came into community and said that these people do not want the leadership to keep it up and we're taking it over, so we're bringing those people that were here in the beginning. We're bringing them back.

What can we Do about it?
Well, even though they're gonna build it up and build it back, most of the people that were here from the beginning, do not either want to come back, have not been brought back, are not gonna come back because of the stipulation that is at hand.

Nice House for Bad Use by an 18-year old female

What do you See here?
A beautiful bright yellow house.

What is really Happening here?
A nice house being used for prostitution and drug trafficking.

How does this relate to Our lives?
I live two houses down from this house and it is bad to have those kinds of houses around close to residents. In this case, any and every type of person may come through there.

Why does this situation, concern, or strength exist?
This is a major concern because I have recently been approached by a stranger that almost led to an assault and I have seen him come out of this house.

What can we Do about it?
Alert the police.

Water Leaks by a 33-year old female

What do you See here?
This is a picture of my pipes leaking under my sink.

What is really Happening here?
It started about two weeks ago, but they told me there's nothing they can do about it since they're gonna tear it down anyway. The wood's rotting out.

How does this relate to Our lives?
It's a health hazard. If it keeps happening it will lead to mold and mold causes asthma.

Why does this situation, concern, or strength exist?
It goes back to maintenance…poor maintenance.

What can we Do about it?
Take a step up, people aren't taking enough initiative. You have to go over the heads of the people who aren't responding.

Rats Gone Wild by a female of unknown age

What do you See here?
You can see one rat, but there were really two more there, you just can't see them. They all scattered. It's behind the B building in McDaniel Glenn.

What is really Happening here?
Trash that attracts the rats. They run all over the place

How does this relate to Our lives?
The rats run into my house. I had complained to the rental office after killing them and trying to get rid of them myself because the rat poison is dangerous for my kids. Someone came out and killed them, but they're back.

Why does this situation, concern, or strength exist?
The abandon buildings, rundown houses bring trash and that attracts the rats. Also certain pipes are broken which bring human waste outside and attract infestation problems.

What can we Do about it?
I complain and complain, but they don't do nothing. Just keep complaining until they listen.

Church versus Community: How Many Churches Does it Take?
by a 31-year old female

What do you See here?
A church zone sign. In the background is a residential area and a church.

What's really Happening here?
One of several churches in the neighborhood. What's really happening here is what's not happening. And that is, why aren't the churches connected?

How does this relate to Our lives?
I feel like our neighborhoods are really in need of support from all of the organizations and resources in the neighborhood and churches are resources that we need. I feel like we won't have sustainability if we uplift all the other organizations and say let's work together and churches still operate within their own parameters.

Why does this situation, concern or strength exist?
I don't know. When I watch TV, I see the churches in the neighborhoods and they know their neighbors. It seems like a concept that should be happening in the community.

What can we Do about it?
Try to make the connection. Make it so that it's not really an option.

What's the Buzz? by a 46-year old female

What do you See here?
Unaffordable houses for existing residents.

What is really Happening here?
We are being set up to fail and being forced out, especially renters.

How does this relate to Our lives?
We are at a loss or a stand still. We are really at war.

Why does this situation, concern, or strength exist?
We got tired. We stopped coming to the table to voice our own opinion about where we stand. A lot of distrust is going on.

What can we Do about it?
Make sure the builders have a plan or a buyer before they build.

Too Hood to Care by a 22-year old female

What do you See here?
A guy who is walking down the street with a message on his t-shirt that says too hood to care.

What is really Happening here?
This message on this t-shirt is actually giving a different meaning than what it seems. And to me, what I got from that meaning was you said that you're too hood to care, do you mean do you not care about anything that goes on in your life? Or you're just so wrapped up in everything else that you just don't care about anything. So, that sort of made me think, is that where he was coming from?

How does this relate to Our lives?
It relates to our lives because in some ways it really says to us do you really not care? Or is that the only hope that you may have.

Why does this situation, concern, or strength exist?
Are blacks brainwashing themselves into thinking that there isn't a way out?

What can we Do about it?
Stress to our community to educate themselves, no matter what it's about.

REFERENCES

(1947). "The Universal Declaration of Human Rights." Retrieved December 15, 2007, from http://www.un.org/events/humanrights/2007/.

(1979). Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention, US Department of Health, Education, and Welfare**:** 1-9.

(2000). Healthy People 2010, US Department of Health and Human Services.

(2004). Neighborhoods Count: A Look at NPU-V in 2004, Annie E. Casey Foundation Atlanta Civic Site.

(2006). "Atlanta Development Authority: 2006 Highlights." Retrieved October 5, 2007, from http://www.atlantada.com/media/2006ADAHighlights_000.pdf.

(2006). Deaths: Preliminary Data for 2004. National Vital Statistics Reports, National Center for Health Statistics. **54:** 1-50.

(2006). National Healthcare Disparities Report, Agency for Healthcare Research and Quality.

(2006). Random House Unabridged Dictionary, Random House.

(2007). "Atlanta Housing Authority Corporate Profile." Retrieved December 13, 2007, from http://www.atlantahousingauth.org/profile/index.cfm.

(2007). "BeltLine: Atlanta Connected." 2007, from http://www.beltline.org/.

(2007). "Poverty Guidelines." Retrieved January 17, 2008, from http://aspe.hhs.gov/poverty/index.shtml.

(2008). "The People's Institute for Survival and Beyond." Retrieved January 20, 2008, from http://www.pisab.org/.

Adler, N. and K. Newman (2002). "Socioeconomic Disparities in Health: Pathways and Policies." Health Affairs **21**(2): 60-76.

Allison, A. (1954). "Protection Afforded by Sickle-Cell Trait against Subtertian Malarial Infection." British Medical Journal **1**(4857): 290-294.

Almedom, A., Z. Mohammed, et al. (2005). "Prolonged Displacement may Compromise Resilience in Eritrean Mothers." African Health Sciences **5**(4): 310-314.

Aron, C. (2001). The Evolution of the Middle Class. A Companion to 19th Century America. W. Barney. Malden, MA, Blackwell Publishers.

Bassett, D., E. Fitzhugh, et al. (2002). "Physical Activity and Ethnic Differences in Hypertension Prevalence in the United States." Preventive Medicine **34**: 179-186.

Bell, A. C., L. Adair, et al. (2004). "Understanding the Role of Mediating Risk Factors and Proxy Effects in the Association between Socio-economic Status and Untreated Hypertension." Social Science and Medicine **59**: 275-283.

Bennett, G., M. Marcellus, et al. (2004). "Stress, Coping, and Health Outcomes among African Americans: A Review of the John Henryism Literature." Psychology and Health **19**(3): 369-383.

Black, D. (1980). Inequalities in Health, HMSO.

Bolton, P., J. Bass, et al. (2007). "Interventions for Depression Symptoms among Adolescent Survivors of War and Displacement in Northern Uganda." Journal of the American Medical Association **298**: 519-527.

Bonilla-Silva, E. (1996). "Rethinking Racism: Toward a Structural Interpretation." American Sociological Review **62**: 465-480.

Boston, T. (2005). "The Effects of Revitalization on Public Housing Residents." The Journal of the American Planning Association **71**(4): 393-407.

Bradley, C., C. Given, et al. (2002). "Race, Socioeconomic Status, and Breast Cancer Treatment and Survival." Journal of the National Cancer Institute **94**(7): 490-6.

Braveman, P. (2006). "Health Disparities and Health Equity: Concepts and Measurement." Annual Review of Public Health **27**: 18.1-18.28.

Brawley, O. (2002). "Disaggregating the Effects of Race and Poverty on Breast Cancer Outcomes." Journal of the National Cancer Institute **94**(7): 471-473.

Charmaz, K. (1994). Learning Grounded Theory. Rethinking Psychology. J. Smith, R. Harre and L. Van Langenhove. London, Sage.

Clark, R., N. Anderson, et al. (1999). "Racism as a Stressor for African Americans: A Biopsychosocial Model." The American Psychologist **54**: 805-816.

Cohen, D., K. Mason, et al. (2003). "Neighborhood Physical Conditions and Health." American Journal of Public Health **93**(3): 467-471.

Cohen, D., S. Spear, et al. (2000). ""Broken Windows" and the Risk of Gonorrhea." American Journal of Public Health **90**(2): 230-236.

Cooper, R. (1984). "A Note on the Biologic Concept of Race and its Application in Epidemiologic Research." American Heart Journal **108**(3(part 2)): 715-723.

Cooper, R., C. Rotimi, et al. (1997). "The Prevalence of Hypertension in Seven Populations of West African Origin." American Journal of Public Health **87**(2): 160-168.

Cooper, R., C. Rotimi, et al. (1997). "Prevalence of NIDDM among Populations of the African Diaspora." Diabetes Care **20**(3): 343.

Corburn, J. (2007). "Reconnecting with our Roots: American Urban Planning and Public Health in the Twenty-first Century." Urban Affairs Review **42**(5): 688-713.

Creswell, J. (1998). Qualitative Inquiry and Research Design: Choosing among the Five Traditions. Thousand Oaks, CA, Sage.

Crotty, M. (1998). Foundations of Social Research: Meaning and Perspective in the Research Process. London, Sage Publications.

Cruickshank, J., J. Mbanya, et al. (2001). "Sick Genes, Sick Individuals or Sick Populations with Chronic Disease? The Emergence of Diabetes and High Blood Pressure in African-origin Populations." International Journal of Epidemiology **30**: 111-117.

Curtin, P. (1992). "The Slavery Hypothesis for Hypertension among African Americans: The Historical Evidence." American Journal of Public Health **82**(12): 1681.

Dannenberg, A., R. Bhatia, et al. (2006). "Growing the Field of Health Impact Assessment in the United States: An Agenda for Research and Practice." American Journal of Public Health **96**(2): 262-270.

Davis, J. and T. Smith (1990). General Social Surveys, 1972-1990. Chicago, National Opinion Research Center.

de Jong, K., S. van der Kam, et al. (2007). "The Trauma of Ongoing Conflict and Displacement in Chechnya: Quantitative Assessment of Living Conditions, Psychosocial and General Health Status among War Displaced in Chechnya and Ingushetia." Conflict and Health **1**: 4.

Dressler, W., K. Oths, et al. (2005). "Race and Ethnicity in Public Health Research: Models to Explain Health Disparities." The Annual Review of Anthropology **34**: 231-252.

Dyson, M. E. (2005). Is Bill Cosby Right or Has the Black Middle Class Lost its Mind? New York, NY, Perseus Book Group.

Farley, R. and W. Frey (1994). "Changes in Segregation of Whites from Blacks in the 1980s: Small Steps Toward a More Integrated Society." American Sociological Review **59**: 23-45.

Farley, R., H. Schuman, et al. (1978). "Chocolate City, Vanilla Suburbs: Will the Trend toward Racially Separate Communities Continue." Social Science Research **7**: 319-344.

Farley, R., C. Steeh, et al. (1994). "Continued Racial Residential Segregation in Detroit: Chocolate City, Vanilla Suburbs Revisited." Journal of Housing Research **4**: 1-38.

Farley, R., C. Steeh, et al. (1994). "Stereotypes and Segregation: Neighborhoods in the Detroit Area." American Journal of Sociology **100**(3): 750-780.

Frank, R. (2001). "The Misuse of Biology in Demographic Research on Racial/Ethnic Differences: A Reply to Van Den Oord and Rowe." Demography **38**(4): 563-567.

Freeman, H. (2003). "Commentary on the Meaning of Race in Science and Society." Cancer Epidemiology, Biomarkers and Prevention **12**(March, Suppl.): 232s-236s.

Freire, P. (1970). Pedagogy of the Oppressed. New York, NY, Continuum.

Fullilove, M. (1996). "Psychiatric Implications of Displacement: Contributions from the Psychology of Place." The American Journal of Psychiatry **153**(12): 1516-1523.

Fullilove, M. (2005). Root Shock: How Tearing Up City Neighborhoods Hurts America, and What We Can Do About It. New York, NY, One World Books.

Galea, S., J. Ahern, et al. (2005). "Urban Built Environment and Depression: A Multilevel Analysis." Journal of Epidemiology and Community Health **59**: 822-827.

Gaventa, J. (1981). "Participatory Action Research in North America." Convergence **14**: 30-42.

Geronimus, A. (2000). "To Mitigate, Resist, or Undo: Addressing Structural Influences on the Health of Urban Populations." American Journal of Public Health **90**(6): 867-872.

Geronimus, A., J. Bound, et al. (1999). "Health Inequality and Population Variation in Fertility-Timing." Social Science and Medicine **49**(1623-1636).

Geronimus, A., J. Bound, et al. (2001). "Inequality in Life Expectancy, Functional Status, and Active Life Expectancy across Selected Black and White Populations in the United States." Demography **38**(2): 227-251.

Geronimus, A., J. Bound, et al. (1996). "Excess Mortality among Blacks and Whites in the United States." The New England Journal of Medicine **335**(21): 1552-1558.

Geronimus, A. and J. P. Thompson (2004). "To Denigrate, Ignore, or Disrupt: Racial Inequality in Health and the Impact of a Policy-induced Breakdown of African American Communities." Du Bois Review **1**(2): 247-279.

Giddens, A. (1984). The Constitution of Society: Outline of the Theory of Structuration. Berkeley, CA, University of California Press.

Glaser, B. and A. Strauss (1967). The Discovery of Grounded Theory: Strategies for Qualitative Research. New York, NY, Aldine de Gruyter.

Green, L. (2003). Guidelines for Participatory Research in Health Promotion. San Francisco, CA, Jossey-Bass.

Griffith, D., E. Moy, et al. (2006). "National Data for Monitoring and Evaluating Racial and Ethnic Health Inequities: Where Do We Go from Here?" Health Education and Behavior **33**(4): 470-487.

Grim, C. (1988). "On Slavery, Salt, and the Higher Blood Pressure in Black Americans." Clinical Research **36**: 426A.

Heckler, M. (1985). Report of the Secretary's Task Force on Black and Minority Health. Washington, D.C., US Department of Health and Human Services.

Heflin, C. and M. Pattillo (2006). "Poverty in the Family: Race, Siblings, and Socioeconomic Heterogeneity." Social Science Research **35**(4): 804-822.

Hill, R. (1993). Research on the African-American Family: A Holistic Perspective. Westport, CT, Auburn House.

Holder, H. and A. Treno (1997). "Media Advocacy in Community Prevention: News as a Means to Advance Policy Change." Addiction **92**: S189-S199.

House, J., R. Kessler, et al. (1990). "Age, Socioeconomic Status, and Health." Milbank Memorial Quarterly **68**: 383-411.

Israel, B., A. Schulz, et al. (2006). "Engaging Urban Residents in Assessing Neighborhood Environments and their Implications for Health." Journal of Urban Health **83**(3): 523-539.

Israel, B., A. Schulz, et al. (2003). Critical Issues in Developing and Following Community-Based Participatory Research Principles. San Francisco, CA, Jossey-Bass.

Israel, B., A. Schulz, et al. (1998). "Review of Community-Based Research: Assessing Partnership Approaches to Improve Public Health." Annual Review of Public Health **19**: 173-202.

James, S. (1983). "John Henryism and Blood Differences Among Black Men." Journal of Behavioral Medicine **6**: 259-278.

James, S. (1987). "Socioeconomic Status, John Henryism and Hypertension in Blacks and Whites." American Journal of Epidemiology **126**: 664-673.

James, S. (1992). "Socioeconomic Status, John Henyrism, and Blood Pressure in Black Adults: The Pitt County Study." American Journal of Epidemiology **135**: 59-67.

James, S. (1994). "John Henryism and the Health of African-Americans." Culture, Medicine and Psychiatry **18**: 163-182.

Jonas, B. and J. Lando (2000). "Negative Affect as a Prospective Risk Factor for Hypertension." Psychosomatic Medicine **62**: 188-196.

Kaufman, J. (1995). "In Search of the Hypothesis." Public Health Reports **110**: 662.

Kaufman, J., R. Cooper, et al. (1997). "Socioeconomic Status and Health in Blacks and Whites: The Problem of Residual Confounding and the Resiliency of Race." Epidemiology **8**(6): 621-628.

Kawachi, I., N. Daniels, et al. (2005). "Health Disparities by Race and Class: Why Both Matter." Health Affairs (Millwood) **24**(2): 343-352.

Keating, L. (2000). "Redeveloping Public Housing: Relearning Urban Renewal's Immutable Lessons." Journal of the American Planning Association **66**(4): 384-397.

Krieger, N. (1990). "Racial and Gender Discrimination: Risk Factors for High Blood Pressure?" Social Science and Medicine **30**(12): 1273-1281.

Krieger, N. (2003). "Does Racism Harm Health? Did Child Abuse Exist before 1962?" American Journal of Public Health **93**(2): 194-199.

Krieger, N., J. Chen, et al. (2005). "Painting a Truer Picture of US Socioeconomic and Racial/Ethnic Health Inequalities: The Public Health Disparities Goecoding Project." American Journal of Public Health **95**(2): 312-323.

Krieger, N., D. Rowley, et al. (1993). "Racism, Sexism, and Social Class: Implications for Studies of Health, Disease, and Well-being." American Journal of Preventive Medicine **9 (suppl)**: 82-122.

Krieger, N. and S. Sidney (1996). "Racial Discrimination and Blood Pressure: The CARDIA Study of Young Black and White Adults." American Journal of Public Health **86**(10): 1370-1378.

Krieger, N. and D. Williams (2001). "Changing to the 2000 Standard Million: Are Declining Racial/Ethnic and Socioeconomic Inequalities in Health Real Progress or Statistical Illusion?" American Journal of Public Health **91**(8): 1209-1213.

Kruse, K. (2005). White Flight: Atlanta and the Making of Modern Conservatism. Princeton, NJ, Princeton University Press.

Krysan, M. and R. Farley (2002). "The Residential Preferences of Blacks: Do They Explain Persistent Segregation." Social Forces **80**(3): 937-980.

Kumanyika, S. and C. Morssink (2006). "Bridging Domains in Efforts to Reduce Disparities in Health and Health Care." Health Education and Behavior **33**(4): 440-458.

Lantz, P., J. Lynch, et al. (2001). "Socioeconomic Disparities in Health Change in a Longitudinal Study of U.S. Adults: The Role of Health Risk Behaviors." Social Science and Medicine **53**: 29-40.

Lassiter, M. (2006). The Silent Majority: Suburban Politics in the Sunbelt South. Princeton, NJ, Princeton University Press.

LaVeist, T. (2005). "Disentangling Race and Socioeconomic Status: A Key to Understanding Health Inequalities." Journal of Urban Health **82**(2, Supplement 3): iii26 - iii34.

Levine, R., J. Foster, et al. (2001). "Black-white Inequalities in Mortality and Life-expectancy, 1933-1999: Implications for Healthy People 2010." Public Health Reports **116**: 474-483.

Lewin, K. (1947). Quasi-stationary and Social Equilibria and the Problem of Social Change. New York, NY, Holt, Rinehart, and Winston.

Lieberman, M., A. Hariri, et al. (2005). "An fMRI Investigation of Race-related Amygdala Activity in African-American and Caucasian-American Individuals." Nature Neuroscience **8**(6): 720-722.

Lieberson, S. (1985). Making It Count: The Improvement of Social Research and Theory. Berkeley, CA, University of California Press.

Link, B. and J. Phelan (1995). "Social Conditions as Fundamental Causes of Disease." Journal of Health and Social Behavior **Extra Issue**: 80-94.

Link, B. and J. Phelan (2005). Fundamental Sources of Health Inequalities. Policy Challenges in Modern Health Care. D. Mechanic, L. Rogut, D. Colby and J. Knickman. New Brunswick, NJ, Rutgers University Press.

Lopez, E. (2002). Quality of Life Needs among Rural African American Breast Cancer Survivors from Eastern North Carolina: Blending the Methods of Photovoice and Grounded Theory. Department of Health Behavior and Health Education. Chapel Hill, NC, University of North Carolina at Chapel Hill. **Doctor of Philosophy:** 310.

Lurie, N. (2005). "Health Disparities--Less Talk, More Action." New England Journal of Medicine **353**(7): 727-729.

Maguire, P. (1987). Doing Participatory Research: A Feminist Approach. Amherst, MA, Center for International Education.

McCord, C. and H. Freeman (1990). "Excess Mortality in Harlem." New England Journal of Medicine **322**(3): 173-177.

McEwen, B. and E. Stellar (1993). "Stress and the Individual: Mechanisms Leading to Disease." Archives of Internal Medicine **153**: 2093-2101.

McGinnis, J. and W. Foege (1993). "Actual Causes of Death in the United States." Journal of the American Medical Association **270**(18): 2207-2212.

Mensa, G., A. Mokdad, et al. (2005). "State of Disparities in Cardiovascular Health in the United States." Circulation **111**: 1233-1241.

Minkler, M. and N. Wallerstein (2003). Community-based Participatory Research for Health. San Francisco, CA, Jossey-Bass.

MMWR (1991). "Public Health Consequences of Acute Displacement of Iraqi Citizens -- March - May 1991." Morbidity and Mortality Weekly Report **40**(26): 443-447.

MMWR (2005). "Health Disparities Experienced by Black or African Americans--United States." Morbidity and Mortality Weekly Report **54**(1): 1-3.

MMWR (2005). "Racial/Ethnic Disparities in Prevalence, Treatment, and Control of Hypertension --- United States, 1999--2002." Morbidity and Mortality Weekly Report **54**(1): 7-9.

Mullings, L. (2006). Resistance and Resilience: The Sojourner Syndrome and the Social Context of Reproduction in Central Harlem. San Francisco, CA, Jossey-Bass.

Murray, C., S. Kulkarni, et al. (2006). "Eight Americas: Investigating mortality disparities across races, counties, and race-counties in the United States." *PLoS Med* **3**(9): e260.

Musselman, D., D. Evans, et al. (1998). "The Relationship of Depression to Cardiovascular Disease: Epidemiology, Biology, and Treatment." Archives of General Psychiatry **55**(7): 580-592.

Navarro, V. (1990). "Race or Class Versus Race and Class: Mortality Differentials in the United States." Lancet **336**(8725): 1238-1240.

NCCDPHP. (2004). "The Burden of Chronic Diseases and their Risk Factors: National and State Perspectives 2004." Retrieved September 26, 2007, from http://www.cdc.gov/nccdphp/burdenbook2004/.

Neighbors, H. and D. Williams (2001). The Epidemiology of Mental Disorder, 1985-2000. San Francisco, CA, Jossey-Bass.

O'riordan, T. and J. Camerson (1994). Interpreting the Precautionary Principle. London, Earthscan Publications.

Pattillo, M. (2005). "Black Middle-Class Neighborhoods." Annual Review of Sociology **31**: 305-329.

Peffley, M. and J. Hurwitz (1993). The Political Impact of Racial Stereotypes. Annual Meeting of the American Political Science Association. Washington, D.C.

Phelan, J., B. Link, et al. (1999). "Fundamental Causes " of Social Inequalities in Mortality: A Test of the Theory. American Sociological Association. Chicago, IL.

Pollock, G. (1996). Generations and Geographies in the Visual Arts. London, England, Routledge.

Ross, C. and J. Mirowsky (2001). "Neighborhood Disadvantage, Disorder, and Health." Journal of Health and Social Behavior **42**(3): 258-278.

Sankar, P., M. Cho, et al. (2004). "Genetic Research and Health Disparities." Journal of the American Medical Association **291**: 2985-2989.

Satcher, D., G. Fryer, et al. (2005). "What if we were Equal? A Comparison of the Black-White Mortality Gap in 1960 and 2000." Health Affairs (Millwood) **24**(2): 459-464.

Schensul, S., J. Schensul, et al. (1999). Essential Ethnographic Methods. Walnut Creek, CA, AltaMira Press.

Schoenborn, C., P. Adams, et al. (2004). Health Behaviors of Adults: United States, 1999-2001. Washington, DC, National Center for Health Statistics, Vital Health Statistics.

Schootman, M., E. Andresen, et al. (2007). "The Effect of Adverse Housing and Neighborhood Conditions on the Development of Diabetes Mellitus among Middle-aged African Americans." American Journal of Epidemiology **166**(4): 379-388.

Schulz, A., C. Gravlee, et al. (2006). "Discrimination, Symptoms of Depression, and Self-Rated Health Among African American Women in Detroit: Results From a Longitudinal Analysis." American Journal of Public Health **96**(7): 1265-1270.

Schulz, A. and M. Northridge (2004). "Social Determinants of Health and Environmental Health Promotion." Health Education and Behavior **31**: 455-471.

Schulz, A., D. Williams, et al. (2002). "Racial and Spatial Relations as Fundamental Determinants of Health in Detroit." Milbank Quarterly **80**(4): 677-707.

Schulz, A., S. Zenk, et al. (2005). "Healthy Eating and Exercising to Reduce Diabetes: Exploring the Potential of Social Determinants of Health Frameworks within the Context of Community-Based Participatory Diabetes Prevention." American Journal of Public Health **95**(4): 645-651.

Seeman, T. and B. McEwen (1996). "Impact of Social Environment Characteristics on Neuroendocrine Regulation." Psychosomatic Medicine **58**: 459-471.

Sigelman, L. and S. Tuch (1997). "Metastereotypes: Blacks' Perceptions of Whites' Stereotypes of Blacks." The Public Opinion Quarterly **61**(1): 87-101.

Smith, D. (1987). The Everyday World as Problematic: A Feminist Sociology. Boston, MA, Northeastern University Press.

Stack, C. (1974). All Our Kin: Strategies for Survival in a Black Community. New York, NY, Harper & Row.

Strauss, A. and J. Corbin (1990). Basics of Qualitative Research. Newbury Park, CA, SAGE Publications.

Thernstrom, S. and A. Thernstrom (1997). America in Black and White: One Nation Indivisible, Simon and Schuster.

Tutu, D. (1994). The Rainbow People of God: The Making of a Peaceful Revolution. New York, NY, Doubleday.

Wang, C. (1999). "Photovoice: A Participatory Action Research Strategy Applied to Women's Health." Journal of Women's Health **8**(2): 185-192.

Wang, C., M. A. Burris, et al. (1996). "Chinese Women as Visual Anthropologists: A Participatory Approach to Reaching Policy Makers." Social Science and Medicine **42**(10): 1391-1400.

Wang, C., J. Cash, et al. (2000). "Who Knows the Streets as Well as the Homeless? Promoting Personal and Community Action through Photovoice." Health Promotion Practice **1**(1): 81-89.

Wang, C., S. Morrel-Samuels, et al. (2004). "Flint Photovoice: Community Building among Youths, Adults, and Policymakers." American Journal of Public Health **94**(6): 911-913.

Wang, C. and C. Pies (2004). "Family, Maternal, and Child Health through Photovoice." Maternal and Child Health Journal **8**(2): 95-102.

Weich, S., M. Blanchard, et al. (2002). "Mental Health and the Built Environment: Cross-section Survey of Individual and Contextual Risk Factors for Depression." British Journal of Psychiatry **180**: 428-433.

Whitehead, M. (1992). "The Concepts and Principles of Equity in Health." International Journal of Health Services Research **22**: 429-445.

Williams, D. and C. Collins (1995). "US Socioeconomic and Racial Differences in Health: Patterns and Explanations." Annual Review of Sociology **21**: 349-386.

Williams, D. and C. Collins (2001). "Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health." Public Health Reports **116**: 404-416.

Williams, D., H. Gonzalez, et al. (2007). "Prevalence and Distribution of Major Depressive Disorder in African Americans, Caribbean Blacks, and Non-Hispanic Whites: Results from the National Survey of American Life." Archives of General Psychiatry **64**: 305-315.

Williams, D. and P. B. Jackson (2005). "Social Sources of Racial Disparities in Health." Health Affairs **24**(2): 325-334.

Williams, D., R. Lavizzo-Mourey, et al. (1994). "The Concept of Race and Health Status in America." Public Health Reports **109**(26-41).

Williams, D., H. Neighbors, et al. (2003). "Racial/ethnic Discrimination and Health: Findings from Community Studies." American Journal of Public Health **93**(2): 200-208.

Williams, D. and R. Williams-Morris (2000). "Racism and Mental Health: The African American Experience." Ethnicity and Disease **5**(3/4): 243-268.

Williams, D., Y. Yu, et al. (1997). "Racial Differences in Physical and Mental Health: Socio-economic Status, Stress, and Discrimination." Journal of Health Psychology **2**: 335.

Wilson, J. and G. Kelling (1982). "Broken Windows." The Atlantic Monthly **249**(3): 29-38.

Wilson, T. (1986). "Salt Supplies in West Africa and Blood Pressures Today." Lancet **1**: 784-786.

Wilson, T. and C. Grim (1991). "Biohistory of Slavery and Blood Pressure Differences in Blacks Today: A Hypothesis." Hypertension **17**: I-122-I-128.

Woolf, S., R. Johnson, et al. (2004). "The Health Impact of Resolving Racial Disparities: An Analysis of US Mortality Data." American Journal of Public Health **94**(12): 2078-2081.