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Vital places: Facilitators of behavioral and social health mechanisms in low-income neighborhoods

Emily Walton

Dartmouth College, Department of Sociology, 108 Silsby Hall, Hanover, NH 03755, USA

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ABSTRACT

Starkly unequal built and social environments among urban neighborhoods are part of the explanation for health disparities in the United States. This study is a qualitative investigation of the ways that residents of a low-income neighborhood in Madison, WI, use and interpret nearby neighborhood places. Specifically, I ask how and why certain places may facilitate beneficial behavioral and social mechanisms that impact health. I develop the organizing concept of "vital places": nearby destinations that are important to and frequently-used by neighborhood residents, and that have theoretical relevance to health. I argue that conceiving of certain places as vital integrates our understanding of the essential components of places that are beneficial to health, while also allowing policy-makers to be creative about the ways they intervene to improve the life chances of residents in disadvantaged neighborhoods. I synthesize the findings into the characteristics of three types of vital places. First, I find that a convenient, comprehensive, and affordable food source can facilitate a healthy diet. An attractive, accessible, and safe recreational facility can support greater physical and social activity. Finally, shared, casual, focused social spaces provide opportunities to create and sustain supportive social ties. This study adds depth and complexity to the ways we conceptualize health-relevant community assets and provides insight into revitalization strategies for distressed low-income housing.

1. Introduction

At the center of this study is a concern with how individuals living in low-income housing – among those with the highest risk for poor health and neighborhood structural disadvantage – interact with their environments. In order to strengthen low-income housing residents' capacity to live better, healthier lives, researchers and policy-makers must understand the behavioral and social mechanisms through which a neighborhood's structural environment influences individual health (Corburn, 2005). A substantial literature in public health identifies the ways that neighborhoods are associated with health behaviors, such as walking for exercise (Berke et al., 2007) and accessing healthy food (Morland et al., 2002). Social science investigations, on the other hand, focus more on understanding the ways in which health is linked to aspects of social processes in neighborhoods, like social support (Carpiano, 2007) and willingness to intervene on the behalf of the public good (Sampson, 2012). I ground the current study at the nexus of these traditions, taking an integrative approach to understanding the multiple ways people experience places in and near their low-income neighborhood.

I introduce the concept of "vital places": nearby places in the neighborhood that are both important to and frequently-used by residents, and that are theoretically related to health through behavioral and/or social mechanisms. While extensive previous research has done a good job establishing that certain neighborhood places, like green spaces (Maas et al., 2009) and healthy food establishments (Morland and Evenson, 2009), can be important for health, the qualitative nature of the current study allows us to delve into *how* and *why* places like these may matter for certain social and behavioral mechanisms that relate to health. The qualitative focus inherently means that this study cannot be conclusive of a causal link between neighborhood features and health. Rather, the main contribution of this study is its ability to unpack the complex and multi-faceted processes through which vital places may enable residents of a multiethnic, low-income neighborhood to enact health-related physical and social behaviors. I ground the analyses in the idea that places can facilitate both behavioral and social processes that are related to health, and generalize these findings to a set of abstract principles regarding the use of vital places as an organizing concept. I argue that focusing on the qualities of places

E-mail address: emily.c.walton@dartmouth.edu.

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that make them vital encourages a more creative, holistic understanding the multiple mechanisms through which neighborhood places are related to individual health.

2. Background

I draw on two main orientations in this study. Public health, urban design, and land use planning disciplines broadly conceive of neighborhoods as collections of physical resources and opportunities that are related to health behaviors, like healthy diet or physical activity; I refer to these as *behavioral mechanisms* through which neighborhoods are associated with health. Social scientific neighborhood research focuses on the ways that neighborhoods influence social relationships, which can enable or constrain social support or action on behalf of others in the community; I refer to these as *social mechanisms* through which neighborhoods are associated with health.

2.1. Behavioral mechanisms

The built environment, broadly defined as "the human-made space in which people live, work and recreate on a day-to-day basis" (Roof and Oleru, 2008), plays an important role in supporting behavioral choices that can manifest in health outcomes. Generally speaking, built environments are organized in ways that are substantially less-supportive of good health in poor, urban neighborhoods (Lovasi et al., 2009). Many excellent recent studies have inquired into the built environment for physical activity by measuring neighborhood features such as residential density (Bedimo-Rung et al., 2005) and street connectivity (Saelens et al., 2003). My focus here, however, is on two specific place-based features of the built environment that are particularly relevant to the concept of vital places – the food environment and the presence of destinations within walking distance – because they represent features of self-contained places within the neighborhood that can enable or inhibit healthy behaviors.

Recently, research on obesity has broadened its focus to understanding the ways neighborhood environments may both encourage excessive food intake and discourage consumption of healthy food (Cummins and Macintyre, 2006; Larson et al., 2009). Obesity and obesity-related comorbidities are higher among individuals of low socioeconomic status (Paeratakul et al., 2002) and, because dietary patterns are influenced by neighborhood resources (Morland et al., 2002), researchers have proposed that neighborhood environments lacking access to healthy food and opportunities for physical activity are "obesogenic" (Lovasi et al., 2009; Reidpath et al., 2002). Proximity to supermarkets, which are considered beneficial because they tend to provide better availability and selection of high-quality foods at a lower cost than other types of stores, is associated with healthier BMI and lower prevalence of obesity (Morland and Evenson, 2009). Residents of disadvantaged neighborhoods, however, are less able to access supermarkets and disproportionately rely on nearby bodegas, convenience stores, and small grocery stores that can have inadequate selection of a diverse range of healthy foods (Cannuscio et al., 2013; Gibson, 2011). Research has not conclusively established, however, that locational access to healthy food sources affects healthy food choices (Mason et al., 2013; Pearce et al., 2008).

Individual engagement in physical activity results to some degree from personal choice, but is also a function of the built environment (Ferdinand et al., 2012). One aspect of the built environment, the presence and mix of attractive destinations in and around a neighborhood, has been found to be associated with increased physical activity (Berke et al., 2007), a behavioral mechanism linking neighborhood structure to health. Access to certain types of destinations like post offices, convenience stores, schools, transit stops, and shopping malls is associated with transport-related walking, not walking for recreation or exercise (McCormack et al., 2008). Powell et al. (2003) emphasize the importance of convenience in the choice to walk for exercise in one's neighborhood; in their study, respondents with the ability to get to places less than ten minutes from their home were most likely to be physically active. On the other hand, some studies demonstrate that it is the quality and attractiveness of the recreational resources that promote greater physical activity, not the proximity of the destination (Kaczynski et al., 2008; Sugiyama et al., 2010). Studies targeting low-income neighborhoods find mixed results, with some reporting no association of physical activity resources (i.e., parks, trails, and community centers) with exercise (Heinrich et al., 2007) and others finding that residents of low-income neighborhoods derive greater benefit from nearby physical activity resources (i.e., gyms and parks) compared to residents of higher-income neighborhoods (Lee et al., 2007).

2.2. Social mechanisms

Social scientists are interested in the ways neighborhood environments are associated with the quantity and quality of social relationships, and ultimately the resources produced from these relationships that can impact health among residents. Persistent segregation in cities across the country by race and socioeconomic status produces profoundly unequal neighborhood environments in the United States (Logan, 2011; Logan and Stults, 2011; Squires and Kubrin, 2005), where the urban poor contend not only with their own poverty, but also with the social effects of living in a neighborhood where most of their neighbors are also poor (Wilson, 1987). Residents of low-income neighborhoods face social isolation from mainstream social ties and institutions that can lead to social mobility (Briggs, 1998), and report having fewer and lower-quality social relationships that may be especially important for individuals faced with economic disadvantage (Smith, 2005; Wacquant and Wilson, 1989). Neighborhood disadvantage is also related to lower levels of social cohesion and social control, resulting in lower trust and poorer quality social relationships among residents (Jencks and Mayer, 1990; Small and Newman, 2001).

Gieryn (2000) suggests that social processes happen through the material forms that we design and build; he contends that neighborhood places arrange patterns of face-to-face interaction that provide bases for social relationships. Some recent work has begun to empirically-examine how neighborhood design can influence social relationships. For instance, Leyden (2003) finds that residents of pedestrian-oriented, mixed-use neighborhoods are more likely than those living in car-oriented neighborhoods to trust others and be socially engaged in their neighborhood.

Because of its demonstrated relationship with health, I conceptually focus here on the resource of social support to which social relationships afford access. Social support refers both to the emotionally-sustaining and instrumentally-beneficial qualities of social relationships (Umberson and Montez, 2010). Morenoff and Lynch (2004) argue that social support is especially important for the health low-income individuals who, in the absence of health-related resources like health insurance, educational skills, and family income, disproportionately rely on resources from their social relationships. Greater social support acts directly to improve physical and mental health (and indirectly as a buffer from the effects of stress) (Cohen, 2004; Uchino, 2006). Providing support to others gives meaning to people's lives by allowing them to fulfill multiple social roles (Thoits, 1995) and can also engender a sense of responsibility to take care of their own health in order to fulfill their