



Perceived Neighborhood Safety During Adolescence Predicts Subsequent Deterioration of Subjective Health Two Decades Later; Gender Differences in a Racially-Diverse Sample

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ABSTRACT

Background: Current study aimed to investigate whether perceived neighborhood as unsafe during adolescence predicts the subsequent perceived health two decades later.

Methods: In a prospective study of an ethnically diverse urban sample (83.2% Black), conducted from 1994 to 2012, 851 adolescents were enrolled at 9th grade. Three hundred and seventy-eight participants were followed from 9th grade for 18 years. The outcome was subjective health (feeling as healthy as other people of the same age) measured at baseline (mean age 15 years) and end of follow-up (mean age 33 years). The independent variable was neighborhood perceived as unsafe measured at 9th grade. Baseline age, family structure, and parental employment were control variables. We ran logistic regressions in the pooled sample and also specific to each gender.

Results: Perceived neighborhood as unsafe at 9th grade predicted deterioration of subjective health over the next 18 years (unadjusted odds ratio = 1.742, 95% confidence interval = 1.042–2.911). This association remained significant in a multivariable model that controlled for baseline subjective health, family structure, and parental employment. The association between perceived neighborhood safety at 9th grade and subsequent deterioration of perceived health during the next 12 years was significant for females but not males.

Conclusions: Our findings suggest that perception of unsafe neighborhoods during adolescence has negative consequences years later for the health of females. Further research is needed to replicate the findings using objective measures of health.

Keywords: Adolescence, adults, life course, neighbourhood, subjective health

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INTRODUCTION

Life course epidemiologists have indicated that health during adulthood may have social antecedents much earlier in life.^[1-5] In this view, health of adults is shaped by developmental factors and processes that are experienced earlier in life.^[6-8] Results of studies

with a life course perspective have major implications for health promotion, as they suggest previously unrecognized opportunities to intervene for health promotion of populations. Specially, findings of life course epidemiological studies advocate for early health interventions.^[9]

Using a life course perspective,^[10-12] the current study uses data from a diverse population (more than 83% either African American or biracial) of youth to investigate whether or not perceived unsafe neighborhood during adolescence predicts subsequent deterioration of subjective health from adolescence to adulthood. Research has suggested that perceived neighborhood safety has implications for health, independent of age, income, and lifestyle.^[13] Neighborhood dissatisfaction has been shown to be associated with an increased prevalence of chronic conditions. Individuals who state that the social aspects of their neighborhood need improvement are more likely to report poor health.^[13] These studies suggest that similar to the objective measures of neighborhood quality,^[14,15] perceptions about neighborhood safety and quality may also have major implications for health.^[16-18]

Most research on the link between place and health has used a cross sectional design. As a result, existing knowledge is limited about the long-term longitudinal association between perceptions about neighborhood and subsequent changes in health. Previous research has shown that neighborhood characteristics (i.e. physical and social environments) and health may have reciprocal effects.^[13,19-23] Perceptions of the physical and social environments not only reflect quality of neighborhood, they may also be influenced by individual attributes such as health status.^[13] People with poor health may have higher tendencies to endorse negative views about their neighborhoods and people with pessimistic views and high neuroticism may more frequently report their health and neighborhoods as poor.^[17,24] Thus, there is still a need to study whether or not baseline perceived neighborhood quality predicts subsequent change in health, independent of baseline health status.

Using a life course perspective,^[25-30] the current longitudinal study investigates: (1) Whether perceiving neighborhood as unsafe during adolescence predicts subsequent deterioration in perceived health from adolescence to adulthood, and (2) if men and women differ in the association between perceived neighborhood safety during adolescence and subsequent change in perceived health from adolescence to early adulthood. We hypothesized that perceiving neighborhood as unsafe during adolescence would be predictive of a worse trajectory of perceived health from adolescence to adulthood. We also expected a gender difference in

the association between perceived neighborhood safety during adolescence and subsequent change in perceived health, as literature suggests that women may be more prone to the cognitive and behavioral effects of their environments.^[31-33]

METHODS

Data came from the Flint Adolescent Study (FAS), a longitudinal cohort from 1994 to 2012 (author). The FAS enrolled 850 adolescents from four public high schools in a city in the Midwest (53% of the population Black or African American based on 2000 Census). Baseline data collection was done at the 9th grade, and participants were followed to their adulthood (18 years of follow-up).

All participants were at high risk for school dropout. Eligibility criteria included having a grade point of 3.0 or lower at the end of the 8th grade, not having been diagnosed by the school as having emotional or developmental impairments, and being either of African American, White, or Bi-racial ethnic group (composed of African American and White).

Measures

Perceived neighborhood safety was measured using the following three items. (1) My neighborhood is a safe place to be. (2) I am afraid of the violence in my neighborhood, and (3) I am afraid I will get hurt by someone in my neighborhood. Items 2 and 3 were reverse coded. Response options included strongly disagree (1), disagree (2), agree (3), and strongly agree (4). Thus, the potential total score varied from 3 to 12, with a higher score indicative of unsafe neighborhood (Cronbach alpha = 0.60).

Perceived health was measured as being as healthy as other people of the same age. The item was "Do you think you are healthier than most people your age, not as healthy as most of them, or do you think that your health is just about the same as most people your age?" Responses included: (1) Healthier than others, (2) about the same, and (3) not as healthy as others. Perceived health was dichotomized into: (1) Poor health (not as healthy as others) and (2) good health (healthier than others or about the same).

Age, gender, family structure, and parental socioeconomic status (SES) (employment and education) at baseline were also measured [Appendix 1].

Ethics

The University of Michigan Institutional Review Board approved the study protocol for all years of data collection and all participants provided assent and consent for participation in the study.

Data analysis

We used SPSS 20 (IBM Corporation NY, USA) for our data analysis. We dichotomized perceived unsafe neighborhood, and perceived health. In our analysis, perceived unsafe environment at ninth grade and perceived health 18 years later were considered as exposure and outcome, respectively. Age, gender, family structure, parental employment, and perceived health at baseline were control variables. Age, parental employment, and family structure at baseline were all dichotomous variables. The current analysis only included 378 individuals who had data on baseline and follow-up measure. We compared those who entered to our analysis and those who did not for all baseline variables. We fitted three logistic regressions to the data. First, we fitted a logistic regression model to the pooled sample. Then, we ran our models specific to gender. Odds ratio and 95% confidence interval were reported. $P < 0.05$ was considered as statistically significant.

RESULTS

At baseline, adolescents varied in age from 14 to 17 years, with a mean age of 15 years (63.8% of the participants were either 13 or 14 years old). Half of the sample were males, and 83.2% were either Black or Bi-racial. Only in 28.4%, the adolescent was living in an intact family with biological mother and father, and only in 48.3%, both parents were employed.

At baseline, 10.2% reported poor subjective health (worse health than others of same age). Based on responses to neighborhood safety, 34.6% of participants were categorized as those who feel their neighborhood is unsafe. From those who stayed in the study, 21.2% reported poor subjective health at the end of follow-up. Table 1 describes study variables including socio-demographic factors, perceived health, and perceived safety at baseline and perceived health at follow-up.

From 851 total participants, 378 (44.4%) stayed in the study for 18 years. Our analysis showed that those who remained and those who dropped out were not significantly different in age, family structure, parental employment, perceived health and perceived safety at baseline. However, drop out was more frequent among males than females [Table 2].

Based on bivariate analysis, female gender, perceived unsafe neighborhood, and perceived poor health at baseline were positively associated with odds of poor subjective health at follow-up [Table 3].

The association between baseline perceived neighborhood safety and perceived health at follow-up was significant in a logistic regression that controlled for all study covariates. Based on our model, perceived unsafe neighborhood, perceived health and parental employment at baseline were associated with perceived health at follow-up [Table 4].

Table 1: Socio-demographic factors, perceived neighborhood and subjective health among 851 adolescents

Characteristics	All	
	<i>n</i>	Valid (%)
Gender		
Male	425	50.0
Female	425	50.0
Minority		
No	143	16.8
Yes	707	83.2
Age		
13 or 14	542	63.8
15 or 16	308	36.2
Parents working at baseline		
No	419	51.7
Yes	392	48.3
Living in an intact family at baseline		
No	609	71.6
Yes	242	28.4
Perceived unsafe neighborhood at baseline		
No	553	65.4
Yes	293	34.6
Perceived poor health at baseline		
No	760	89.8
Yes	86	10.2
Perceived poor health at follow-up		
No	298	78.8
Yes	80	21.2
Total	851	100.0

The association between perceived neighborhood as unsafe at age 15 and poor perceived health at age 33 was significant among female but not male participants. In the logistic regression specific for males, parental employment was the only predictor of perceived health at follow-up. In the logistic regression specific to females, perceived unsafe neighborhood, perceived health and parental employment at age 15 were predictive of perceived health at follow-up [Table 4].

DISCUSSION

The current study examined the association between perceived neighborhood as unsafe during adolescence and deterioration of perceived health from adolescence to early adulthood. This finding supports previous life course epidemiological findings that suggest health during adulthood has social antecedents during childhood and adolescence.^[1-5] Current findings help us better understand early cognitive and emotional processes that may predict subsequent health and illness.^[12] It is unlikely that perceived neighborhood as unsafe is a cause of deterioration of health in the next decades of

Table 2: Factors associated with drop out in the study

	n (%) dropped out	Pearson Chi-square value	P (two-sided)
Gender			
Male	263 (61.9)	13.390	<0.001
Female	210 (49.4)		
Minority			
No	78 (54.5)	0.085	0.771
Yes	395 (55.9)		
Parental employment at baseline			
No	231 (55.1)	0.044	0.833
Yes	219 (55.9)		
Living in an intact family at baseline			
No	336 (55.2)	0.145	0.703
Yes	137 (56.6)		
Age			
13-14	290 (53.5)	2.779	0.095
15-16	183 (59.4)		
Baseline perceived unsafely			
No	299 (54.1)	1.667	0.197
Yes	172 (58.7)		
Baseline perceived poor health			
No	426 (56.1)	0.435	0.510
Yes	45 (52.3)		

Table 3: Bivariate associates of perceived poor health at follow-up

Characteristics	OR	95% CI for OR		P
		Lower	Upper	
Perceived unsafe neighborhood at baseline	1.742	1.042	2.911	0.034
Perceived poor health at baseline	2.808	1.415	5.572	0.003
Female gender	1.838	1.086	3.110	0.023
Minority	1.368	0.678	2.760	0.381
Parents working at baseline	0.401	0.233	0.690	0.001
Living in an intact family at baseline	0.835	0.475	1.470	0.532
Age	0.917	0.539	1.560	0.748

OR=Odds ratio, CI=Confidence interval

life. Rather, unsafe neighborhood perception may be a proxy of a disadvantaged environment and life condition with multiple risk factors that collectively contribute to subsequent deterioration of health.

Our findings are in line with previous studies that have demonstrated the role of neighborhood perceptions as a determinant of health, independent of age, income, and lifestyle.^[13] Researchers have found that living in areas with high rates of crime, homelessness, drug trafficking, and prostitution has strong effects on the health of

residents.^[13] Based on our findings, interventions at the neighborhood level that reduce violent crime and enhance perceived safety may slow the process of deterioration of health of residents living in unsafe and often poor neighborhoods. Diez Roux *et al.* have emphasized the need for efforts at the neighborhood level in order to enhance well-being of individuals.^[65]

In addition to the effect of the social environment on health,^[19,34-41] individual health may also be influenced by physical aspects of the neighborhood.^[42] Most^[19,34,37,43,44] but not all studies^[45] from different countries have suggested that social environment may be linked to self-reported health. In a study in Alabama metropolitan area among 100 children aged 7–12, perceived neighborhood disorder was associated with increased energy intake and sodium intake and decreased potassium levels.^[46] Among 101 African American adolescents age 12–16 years, perceived neighborhood disorder was associated with poor physical activity and increased obesity.^[47] Negative perception of neighborhood characteristics has been linked to poor self-rated health as well.^[43,48]

High quality social environment may promote people's sense of management of stress and control over life. In such circumstances, the adverse impact of challenging life events may be at minimum.^[49] Availability of social support and social network members and vibrant formal and informal community organizations may help people make connections with each other, construct and maintain relationships of trust and reciprocity that all protect health. Social organizations at the neighborhood-which can be captured in social capital and cohesion-are important for the health of community members.^[44,50] Communities that are short in social organizations, resources, trust, and safety deteriorate health.^[51] Future research that explores what ingredients of social environment (i.e., connection, social support and participation at social organizations) mediate the effect of perceived social environment on health would be useful. Our results also suggest that testing how change in social environment influences subsequent change in health would be a logical next step for future research.^[52-58]

Multiple studies have shown that different measures of social environment (i.e. social capital and cohesion) potentially affect health of populations. Connecting with family, friends, colleagues, and associating with social network members have protective health effects.^[59] Social support buffers against the effect of stress, and reduces feeling of vulnerability and insecurity at the time of exposure to difficulties. Having strong social relations also provides the opportunity for mobilizing material and emotional resources that protect health.^[60,61]

In 2004, Wilson *et al.*, tested the association between perceptions of physical and social characteristics of

Table 4: Summary of logistic regression among all, male and female participants to predict perceived poor health at follow-up

Characteristics	B	SE	OR	95% CI for OR		P
				Lower	Upper	
All*						
Perceived unsafe neighborhood at baseline	0.653	0.280	1.921	1.110	3.325	0.02
Perceived poor health at baseline	1.041	0.369	2.832	1.375	5.835	0.005
Parents working at baseline	-0.915	0.291	0.401	0.226	0.709	0.002
Living in an intact family at baseline	0.078	0.311	1.082	0.588	1.990	0.80
Gender (female/male)	0.525	0.288	1.690	0.961	2.971	0.06
Males**						
Perceived unsafe neighborhood at baseline	0.100	0.513	1.105	0.404	3.019	0.84
Perceived poor health at baseline	1.106	0.698	3.022	0.770	11.868	0.11
Parents working at baseline	-1.432	0.549	0.239	0.081	0.701	0.009
Living in an intact family at baseline	0.308	0.514	1.361	0.497	3.728	0.54
Females**						
Perceived unsafe neighborhood at baseline	0.867	0.349	2.380	1.202	4.714	0.01
Perceived poor health at baseline	0.989	0.434	2.689	1.149	6.291	0.02
Parents working at baseline	-0.728	0.357	0.483	0.240	0.972	0.04
Living in an intact family at baseline	0.042	0.404	1.043	0.473	2.301	0.91

*Baseline age, gender, subjective health, family structure, parental employment, and perceived unsafe neighborhood were in the model, **Baseline age, subjective health, family structure, parental employment, and perceived unsafe neighborhood were in the model. OR=Odds ratio, CI=Confidence interval, SE=Standard error

neighborhood and three health outcomes including self-assessed health status, chronic conditions, and emotional distress in Canada. The study documented significant differences across neighborhoods in self-assessed health status and emotional distress, but not in prevalence of chronic conditions. Although, residents of neighborhoods with lower SES reported poorer health and more emotional distress, compared to others, they did not report higher number of chronic medical conditions.^[13]

In a study that measured neighborhood violent crime, subjective perceptions of neighborhood and depression among 5688 individuals aged 50–74 living in New Jersey, neighborhood violent crime and perceived neighborhood safety were associated with depressive symptoms. The association in that study was above and beyond age, sex, and household income.^[25]

Our findings are consistent with previous studies that report links between residing in economically deprived areas and poor subjective health.^[4,5,10] Based on the New Haven Established Populations for Epidemiologic Studies of the Elderly, after 8 years of follow-up, perceiving safety hazards was associated with increased risk of mobility disability among elders at retirement age whose income was below poverty line. This study was a longitudinal cohort of community-dwelling elders aged 65 and older and measured perceptions of neighborhood safety due to crime, mobility (ability to climb stairs and walk a half mile), annual household income, lifestyle characteristics (smoking, alcohol use, physical activity), presence of chronic co-morbid conditions at the individual level and crime rates at the census tract level.

Interestingly, actual crime rate was not associated with health outcomes in any sub-group, but perceived safety did predict health outcomes.^[26]

We found gender differences in the role of perceived neighborhood safety and change in perceived health. In 2015, Assari *et al.* also found gender differences in longitudinal associations between the increase in perceived neighborhood fear and depressive symptoms among African American youth who were in transition to adulthood. Following 513 individuals (235 males and 278 females) from age 20–23, they found that increase in perceived neighborhood fear was associated with an increase in depressive symptoms among males but not females.^[62] The Moving to Opportunity (MTO) study has also found that the benefits associated with change in neighborhood is stronger for girls than boys.^[55] Moving to low-poverty neighborhoods has lowered the risk behavior of girls but not boys. Daily routines, fitting in with neighborhood norms, neighborhood navigation strategies, interactions with peers, friendship making, and distance from father figures have been listed as potential explanatory factors that may explain why the benefits associated with moving to a better neighborhood is stronger for girls than boys.^[58] Osypuk *et al.* also explored how gender and crime victimization modify the effect of moving to a lower-poverty neighborhood on distress and problem behaviors. While female adolescents in families without crime victimization benefited from MTO treatment, for all outcomes, male adolescents did worse following a change in neighborhood in terms of distress and problem behaviors and major depressive disorder. Girls from families experiencing recent violent crime

victimization showed less benefit associated with moving to a better neighborhood.^[57]

Our study had several limitations. Although perceived neighborhood safety, and SES are dynamic and expected to change over time, we only measured them at baseline. Future research should operationalize these factors as time varying covariates. The study did not measure objective health, but subjective health. The study also did not use a representative sample, thus the results are not be representative to all adolescents and young adults who live in the US. The current study measured perceived neighborhood safety using 3-item, and perceived health using a single item. Although single item measures of health are valid,^[63,64] future research may use more detailed measures. Future research may also include subjective and objective measures of neighborhood.^[42,47,65-68]

Despite these limitations, using a longitudinal design with 18 years of follow-up was a significant strength of the study. Few researchers have examined the effects of neighborhood perceptions on such a long follow-up sample. In addition, our sample characteristics include participants that are not often the focus of research. Our study also contributes to burgeoning evidence about the effects of disorganized neighborhood context (perceived or not) on subsequent health.

CONCLUSIONS

This study provides useful information about how perceived neighborhood safety in adolescence has pernicious and persistent effects into the health and well-being of adults who grow up in urban areas. Our study suggests that further research examining the effects of neighborhood perceptions is necessary to replicate and further understand how they may effect health disparities. In addition, future research that examines those factors may help residents overcome the negative effects of fear of neighborhood violence (resilience) would be especially useful to help define factors that might be vital for health promotion in such conditions.^[69]

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REFERENCES

1. Evrard SG. Prenatal alcohol exposure as an etiological factor in neuropsychiatric diseases of childhood, adolescence and adulthood. *Vertex* 2010;21:260-5.
2. Kuh D, Ben-Shlomo Y, editors. *A Life Course Approach to Chronic Disease Epidemiology: Tracing the Origins of Ill-Health from Early to Adult Life*. Oxford, UK: Oxford University Press; 1997.
3. Power C, Hertzman C. Social and biological pathways linking early life and adult disease. *Br Med Bull* 1997;53:210-21.
4. Galobardes B, Smith GD, Lynch JW. Systematic review of the influence of childhood socioeconomic circumstances on risk for cardiovascular disease

- in adulthood. *Ann Epidemiol* 2006;16:91-104.
5. Galobardes B, Lynch JW, Davey Smith G. Childhood socioeconomic circumstances and cause-specific mortality in adulthood: Systematic review and interpretation. *Epidemiol Rev* 2004;26:7-21.
6. Pollitt RA, Rose KM, Kaufman JS. Evaluating the evidence for models of life course socioeconomic factors and cardiovascular outcomes: A systematic review. *BMC Public Health* 2005;5:7.
7. Berkman LF. Social epidemiology: Social determinants of health in the United States: Are we losing ground? *Annu Rev Public Health* 2009;30:27-41.
8. Gjelsvik A, Dumont DM, Nunn A. Incarceration of a household member and Hispanic health disparities: Childhood exposure and adult chronic disease risk behaviors. *Prev Chronic Dis* 2013;10:E69.
9. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med* 1998;14:245-58.
10. Liu S, Jones RN, Glymour MM. Implications of Lifecourse Epidemiology for Research on Determinants of Adult Disease. *Public Health Rev* 2010;32:489-511.
11. Ben-Shlomo Y, Kuh D. A life course approach to chronic disease epidemiology: Conceptual models, empirical challenges and interdisciplinary perspectives. *Int J Epidemiol* 2002;31:285-93.
12. Kuh D, Ben-Shlomo Y, Lynch J, Hallqvist J, Power C. Life course epidemiology. *J Epidemiol Community Health* 2003;57:778-83.
13. Wilson K, Elliott S, Law M, Eyles J, Jerrett M, Keller-Olaman S. Linking perceptions of neighbourhood to health in Hamilton, Canada. *J Epidemiol Community Health* 2004;58:192-8.
14. Lovasi GS, Neckerman KM, Quinn JW, Weiss CC, Rundle A. Personal and neighborhood socioeconomic status and indices of neighborhood walk-ability predict body mass index in New York City. *Soc Sci Med* 2008;67:1951-8.
15. Rundle A, Field S, Park Y, Freeman L, Weiss CC, Neckerman K. Effect of individual or neighborhood disadvantage on the association between neighborhood walkability and body mass index. *Am J Public Health* 2009;99:279-84.
16. Wilson-Genderson M, Pruchno R. Effects of neighborhood violence and perceptions of neighborhood safety on depressive symptoms of older adults. *Soc Sci Med* 2013;85:43-9.
17. Clark CR, Kawachi I, Ryan L, Ertel K, Fay ME, Berkman LF. Perceived neighborhood safety and incident mobility disability among elders: The hazards of poverty. *BMC Public Health* 2009;9:162.
18. Balfour JL, Kaplan GA. Neighborhood environment and loss of physical function in older adults: Evidence from the Alameda County Study. *Am J Epidemiol* 2002;155:507-15.
19. Ellaway A, Macintyre S, Kearns A. Perceptions of place and health in socially contrasting neighbourhoods. *Urban Stud* 2001;38:2299-316.
20. Steptoe A, Feldman PJ. Neighborhood problems as sources of chronic stress: Development of a measure of neighborhood problems, and associations with socioeconomic status and health. *Ann Behav Med* 2001;23:177-85.
21. Macintyre S, Ellaway A, Cummins S. Place effects on health: How can we conceptualise, operationalise and measure them? *Soc Sci Med* 2002;55:125-39.
22. Cattell V, Herring R. Social capital, generations and health in East London. In: Swann C, Morgan A, editors. *Social Capital for Health: Insights from Qualitative Research*. London: Health Development Agency; 2002. p. 61-85.
23. Skjaeveland O, Garling T. Effects of interactional space on neighbouring. *J Environ Psychol* 1997;17:181-98.
24. Mandelli L, Nearchou FA, Vaiopoulos C, Stefanis CN, Vitoratou S, Serretti A, et al. Neuroticism, social network, stressful life events: Association with mood disorders, depressive symptoms and suicidal ideation in a community sample of women. *Psychiatry Res* 2015;226:38-44.
25. McEniry M. Early-life conditions and older adult health in low- and middle-income countries: A review. *J Dev Orig Health Dis* 2013;4:10-29.
26. McEniry M, Palloni A. Early life exposures and the occurrence and timing of heart disease among the older adult Puerto Rican population. *Demography* 2010;47:23-43.
27. McEniry M, Palloni A, Davila AL, García GA. Early life exposure and its effects on the health of older Puerto Rican adults. *J Gerontol Psychol Soc Sci* 2008;63B: S337-48.
28. Palloni A, McEniry M, Dávila AL, Gurucharri AG. The influence of

- early conditions on health status among elderly Puerto Ricans. *Soc Biol* 2005;52:132-63.
29. Palloni A, Milesi C, White RG, Turner A. Early childhood health, reproduction of economic inequalities and the persistence of health and mortality differentials. *Soc Sci Med* 2009;68:1574-82.
 30. Pickles A, Maughan B, Wadsworth M. *Epidemiological Methods in Life Course Research*. Berkshire, UK: Open University Press; 2007. p. 1-26.
 31. Karb RA. *Neighborhood Social and Physical Environments and Health: Examining Sources of Stress and Support in Neighborhoods and their Relationship with Self-rated Health, Cortisol and Obesity in Chicago*; 2010.
 32. Auchincloss AH, Mujahid MS, Shen M, Michos ED, Whitt-Glover MC, Diez Roux AV. Neighborhood health-promoting resources and obesity risk (the multi-ethnic study of atherosclerosis). *Obesity (Silver Spring)* 2013;21:621-8.
 33. Foster S, Giles-Corti B. The built environment, neighborhood crime and constrained physical activity: An exploration of inconsistent findings. *Prev Med* 2008;47:241-51.
 34. Pampalon R, Hamel D, De Koninck M, Disant MJ. Perception of place and health: Differences between neighbourhoods in the Québec City region. *Soc Sci Med* 2007;65:95-111.
 35. Spielman SE, Yoo EH. The spatial dimensions of neighborhood effects. *Soc Sci Med* 2009;68:1098-105.
 36. Collins PA, Hayes MV, Oliver LN. Neighbourhood quality and self-rated health: A survey of eight suburban neighbourhoods in the Vancouver Census Metropolitan Area. *Health Place* 2009;15:156-64.
 37. Wilson K, Eyles J, Elliott S, Keller-Olaman S. Health in Hamilton neighbourhoods: Exploring the determinants of health at the local level. *Health Place* 2009;15:374-82.
 38. Altschuler A, Somkin CP, Adler NE. Local services and amenities, neighborhood social capital, and health. *Soc Sci Med* 2004;59:1219-29.
 39. Wilkinson RG. Income inequality, social cohesion, and health: Clarifying the theory – A reply to Muntaner and Lynch. *Int J Health Serv* 1999;29:525-43.
 40. Song L. Social capital and psychological distress. *J Health Soc Behav* 2011;52:478-92.
 41. Diez Roux AV. Invited commentary: Places, people, and health. *Am J Epidemiol* 2002;155:516-9.
 42. Cohen DA, Mason K, Bedimo A, Scribner R, Basolo V, Farley TA. Neighborhood physical conditions and health. *Am J Public Health* 2003;93:467-71.
 43. Cho Y, Park GS, Echevarria-Cruz S. Perceived neighborhood characteristics and the health of adult Koreans. *Soc Sci Med* 2005;60:1285-97.
 44. Molinari C, Ahern M, Hendryx M. The relationship of community quality to the health of women and men. *Soc Sci Med* 1998;47:1113-20.
 45. Cho Y. *The Impact of Individual and Contextual-Level Characteristics on the Health of Metropolitan Seoul Adult Residents*. Unpublished Doctoral Dissertation, the University of Texas, Austin; 2002.
 46. Keita AD, Casazza K, Thomas O, Fernandez JR. Neighborhood perceptions affect dietary behaviors and diet quality. *J Nutr Educ Behav* 2011;43:244-50.
 47. Dulin-Keita A, Kaur Thind H, Affuso O, Baskin ML. The associations of perceived neighborhood disorder and physical activity with obesity among African American adolescents. *BMC Public Health* 2013;13:440.
 48. Wong T, Yan Y. Perception of neighborhood environments and self-rated health in Hong Kong. *Internet J Public Health* 2012;2: Available from: <https://ispub.com/IJPH/2/1/14116>. [Last accessed on 2015 Apr 15].
 49. Lightman E, Mitchell A, Wilson B. *Poverty is Making Us Sick: A Comprehensive Survey of Income and Health in Canada*. Toronto. Canada: Wellesley Institute; 2008.
 50. Fone D, Dunstan F, Lloyd K, Williams G, Watkins J, Palmer S. Does social cohesion modify the association between area income deprivation and mental health? A multilevel analysis. *Int J Epidemiol* 2007;36:338-45.
 51. Central Policy Unit, Hong Kong Special Administrative Region. A study on mapping the associational life in Tin Shui Wai. The Hong Kong Polytechnic University: Hong Kong; 2009. p. 1-112.
 52. Fauth RC, Leventhal T, Brooks-Gunn J. Short-term effects of moving from public housing in poor to middle-class neighborhoods on low-income, minority adults' outcomes. *Soc Sci Med* 2004;59:2271-84.
 53. Fauth RC, Leventhal T, Brooks-Gunn J. Seven years later: Effects of a neighborhood mobility program on poor Black and Latino adults' well-being. *J Health Soc Behav* 2008;49:119-30.
 54. Kessler RC, Duncan GJ, Gennetian LA, Katz LF, Kling JR, Sampson NA, et al. Associations of housing mobility interventions for children in high-poverty neighborhoods with subsequent mental disorders during adolescence. *JAMA* 2014;311:937-48.
 55. Osypuk TL, Tchetgen EJ, Acevedo-Garcia D, Earls FJ, Lincoln A, Schmidt NM, et al. Differential mental health effects of neighborhood relocation among youth in vulnerable families: Results from a randomized trial. *Arch Gen Psychiatry* 2012;69:1284-94.
 56. Leventhal T, Dupéré V. Moving to Opportunity: Does long-term exposure to 'low-poverty' neighborhoods make a difference for adolescents? *Soc Sci Med* 2011;73:737-43.
 57. Osypuk TL, Schmidt NM, Bates LM, Tchetgen-Tchetgen EJ, Earls FJ, Glymour MM. Gender and crime victimization modify neighborhood effects on adolescent mental health. *Pediatrics* 2012;130:472-81.
 58. Clampet-Lundquist S, Kling JR, Edin K, Duncan GJ. Moving teenagers out of high-risk neighborhoods: How girls fare better than boys. *AJS* 2011;116:1154-89.
 59. Poder TG, He J. Social capital and health: What the empirical literature teaches us? *Glob J Health Sci* 2010;2:3-7.
 60. Ayé M, Champagne F, Contandriopoulos AP. Economic role of solidarity and social capital in accessing modern health care services in the Ivory Coast. *Soc Sci Med* 2002;55:1929-46.
 61. Habtom GK, Ruys P. Traditional risk-sharing arrangements and informal social insurance in Eritrea. *Health Policy* 2007;80:218-35.
 62. Assari S, Smith JR, Caldwell CH, Zimmerman MA. Gender Differences in Longitudinal Links between Neighborhood Fear, Parental Support, and Depression among African American Emerging Adults. *Societies* 2015;5:151-70.
 63. DeSalvo KB, Fan VS, McDonell MB, Fihn SD. Predicting mortality and healthcare utilization with a single question. *Health Serv Res* 2005;40:1234-46.
 64. DeSalvo KB, Bloser N, Reynolds K, He J, Muntner P. Mortality prediction with a single general self-rated health question. A meta-analysis. *J Gen Intern Med* 2006;21:267-75.
 65. Diez Roux AV. Investigating neighborhood and area effects on health. *Am J Public Health* 2001;91:1783-9.
 66. Bowling A, Barber J, Morris R, Ebrahim S. Do perceptions of neighbourhood environment influence health? Baseline findings from a British survey of aging. *J Epidemiol Community Health* 2006;60:476-83.
 67. Poortinga W, Dunstan FD, Fone DL. Perceptions of the neighbourhood environment and self rated health: A multilevel analysis of the Caerphilly Health and Social Needs Study. *BMC Public Health* 2007;7:285.
 68. Ziersch AM, Baum FE, Macdougall C, Putland C. Neighbourhood life and social capital: The implications for health. *Soc Sci Med* 2005;60:71-86.
 69. Fergus S, Zimmerman MA. Adolescent resilience: A framework for understanding healthy development in the face of risk. *Annu Rev Public Health* 2005;26:399-419.

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Appendix 1: Items used in this study

What is your birthdate?

What is your sex?

How do you describe yourself? Are you...

- Black or African-American
- White or Caucasian
- Mixed African-American and White
- Other.

What is the highest level of schooling your mother ("OTHER") completed?

- Completed grade school or less
- Some high school
- Completed high school
- Vocational/training school
- Some college
- Completed college
- Graduate or professional
- No contact with mother
- Don't know/does not apply.

Is your mother ("OTHER") working in a job for pay...

- Full time (30–40 h)?
- Part-time (<30 h)?
- Retired?
- Not working
- Deceased
- Don't know.

What is the highest level of schooling your father completed?

- Completed grade school or less

- Some high school
- Completed high school
- Vocational/training school
- Some college
- Completed college
- Graduate or professional
- No contact with mother
- Don't know/does not apply.

Is your father working in a job for pay...

- Full time (30–40 h)?
- Part-time (<30 h)?
- Retired?
- Not working
- Deceased
- Don't know.

Perceived neighborhood safety

Using this 4-point scale, please tell me how much you agree with the following statements.

My neighborhood is a safe place to be

I am afraid of the violence in my neighborhood

I am afraid I will get hurt by someone in my neighborhood

Perceived Health

On a scale of 1–7, 1 being not at all concerned and 7 being very much concerned, during the last month, how much has your health worried or concerned you?

Do you think you are healthier than most people your age, not as healthy as most of them, or do you think that your health is just about the same as most people your age?

- Healthier than others
- About the same
- Not as healthy as others

